

No. 90-97-CFX
Status: GRANTED -

Title: American Hospital Association, Petitioner
v.
National Labor Relations Board, et al.

-Docketed:
July 10, 1990

Court: United States Court of Appeals
for the Seventh Circuit

Counsel for petitioner: Holzhauer, James D.

Counsel for respondent: Solicitor General, Peterson, Woody
N., Gold, Laurence

NOTE: See mail label re dock dt

Entry	Date	Note	Proceedings and Orders
1	Jul 10 1990	G	Petition for writ of certiorari filed.
2	Aug 9 1990		Brief amicus curiae of Fairfax Hospital System filed.
4	Aug 9 1990		Order extending time to file response to petition until August 20, 1990.
5	Aug 9 1990		One above extension of time applies to all respondents.
8	Aug 10 1990		Brief amicus curiae of American Health Systems filed.
6	Aug 13 1990		Order further extending time to file response to petition until September 6, 1990.
7	Aug 13 1990		The above extension is for all respondents.
15	Sep 5 1990		Brief amicus curiae of St. Francis Hospital, Inc. filed.
9	Sep 6 1990		Brief of respondent American Nurses Association in opposition filed.
10	Sep 6 1990		Brief of respondent United States filed.
11	Sep 6 1990		Brief amici curiae of St. Margaret Memorial Hospital, et al. filed.
12	Sep 6 1990		Brief amici curiae of Missouri Hospital Association, et al. filed.
13	Sep 9 1990		Brief amici curiae of William Beaumont Hospital, et al. filed.
14	Sep 10 1990		Waiver of right of respondent AFL-CIO to respond filed.
16	Sep 12 1990		DISTRIBUTED. October 5, 1990
17	Oct 9 1990		Petition GRANTED. Justice Souter OUT. *****
18	Nov 13 1990		Record filed.
		*	Certified copy of original record and C. A. Proceedings received.
19	Nov 21 1990		Brief amicus curiae of Fairfax Hospital System filed.
20	Nov 21 1990		Brief amicus curiae of Maryland Hospital Assn., Inc. filed.
21	Nov 21 1990		Brief amicus curiae of Greater Cincinnati Hospital Council filed.
23	Nov 21 1990		Lodging received. (10 copies).
25	Nov 21 1990		Brief of petitioner American Hospital Association filed.
27	Nov 21 1990		Brief amici curiae of Missouri Hospital Association, et al. filed.
28	Nov 21 1990		Brief amici curiae of William Beaumont Hospital, et al. filed.
29	Nov 21 1990		Brief amicus curiae of Virginia Hospital Association filed.
30	Nov 21 1990		Brief amici curiae of California Assn. of Hospitals and Health Systems, et al. filed.

No. 90-97-CFX

Entry	Date	Note	Proceedings and Orders
22	Nov 23 1990	Brief amicus curiae of Society for Human Resource Management filed.	
24	Nov 23 1990	Joint appendix filed.	
26	Nov 23 1990	Brief amicus curiae of St. Francis Hospital of Memphis, TN filed.	
31	Nov 23 1990	Brief amici curiae of St. Margaret Memorial Hospital, et al. filed.	
32	Dec 4 1990	Brief amicus curiae of Union of American Physicians and Dentists filed.	
34	Dec 12 1990	D Motion of the Solicitor General for divided argument filed.	
33	Dec 17 1990	SET FOR ARGUMENT MONDAY, FEBRUARY 25, 1991. (1ST CASE)	
36	Dec 20 1990	Order extending time to file brief of respondent on the merits until January 3, 1991.	
38	Jan 3 1991	Brief of respondent NLRB filed.	
39	Jan 3 1991	Brief of respondents American Nurses Association, et al. filed.	
37	Jan 7 1991	Motion of the Solicitor General for divided argument DENIED.	
40	Jan 9 1991	CIRCULATED.	
41	Feb 6 1991	X Reply brief of petitioner American Hospital Association filed.	
42	Feb 7 1991	Ten copies of a lodging received.	
43	Feb 25 1991	ARGUED.	

①

Supreme Court, U.S.
FILED

JUL 10 1990

JOSEPH F. SPANIOL, JR.
CLERK

90 - 97

No.

IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

**PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

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QUESTIONS PRESENTED

The Health Care Amendments Act of 1974 repealed the exemption of most hospitals from the National Labor Relations Act. In taking that action, Congress admonished the National Labor Relations Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." App., *infra*, 8a. Ever since, the Board's attempts to apply to the health care industry the same bargaining unit standards it applies in other industries have met with failure. The courts of appeals have rejected the Board's determinations, usually because they failed to give proper weight to the congressional admonition against proliferation. Responding to this "dismal background" (*Id.* at 15a), in 1987 the Board for the first time in its history decided to engage in formal, substantive rulemaking. The rule it issued provides that eight specific bargaining units (and only those units) are appropriate for every acute-care hospital in the country. The questions presented are:

1. Whether the National Labor Relations Board's rule determining that eight specific bargaining units are appropriate for every acute-care hospital contravenes the requirement of Section 9(b) of the National Labor Relations Act (29 U.S.C. § 159(b)) that "[t]he Board shall decide [the appropriate bargaining unit] in each case."

2. Whether the rule is consistent with the Health Care Amendments Act of 1974 and the congressional admonition to "prevent[] proliferation of bargaining units in the health care industry."

3. Whether the rule is arbitrary and capricious and not based on substantial evidence insofar as it ignores the critical differences among the more than 4,000 private, acute-care hospitals in the United States.

PARTIES TO THE PROCEEDINGS AND RULE 29.1 STATEMENT

In addition to the parties named in the caption, the following entities and individuals were appellants in the court of appeals and are respondents in this Court:

James M. Stephens
 Mary M. Cracraft
 Dennis M. Devaney
 Clifford R. Oviatt, Jr.*
 John C. Truesdale
 American Nurses Association
 American Federation of Labor and Congress
 of Industrial Organization
 Building and Construction Trades
 Department, AFL-CIO

* Substituted as a respondent pursuant to Rule 35.3 of the Rules of this Court.

Pursuant to Rule 29.1 of the Rules of this Court, petitioner American Hospital Association states that it has no parent or subsidiary companies (other than wholly-owned subsidiaries).

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American Hospital Association ("AHA") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-16a) is reported at 899 F.2d 651. The opinion of the district court (App., *infra*, 17a-42a) is reported at 718 F.Supp. 704.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1990. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), and the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-16348 (1989), 29 C.F.R. § 103.30, are set forth at App., *infra*, 43a-46a.

STATEMENT

From 1947 until 1974, most hospitals were excluded from the coverage of the National Labor Relations Act.¹ When Congress amended the law in 1974 to encompass

¹ Before 1974, the Act excluded nonproprietary (i.e., private, not-for-profit) hospitals. They comprise nearly 83% of all private hospitals. American Hospital Ass'n, *Hospital Statistics* 207 (1989-90 ed.). Public employers, including government-owned hospitals, remain excluded from the Act. 29 U.S.C. § 152(2).

all private hospitals, it specifically instructed the National Labor Relations Board that in carrying out its statutory obligation to "decide in each case" the appropriate unit for collective bargaining, it should give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). From 1974 until 1987, the Board's hospital bargaining unit determinations repeatedly were rejected by the courts of appeals, usually on the ground that the Board had ignored the congressional admonition against proliferation of bargaining units.

Clearly frustrated by its failure in the courts (App., *infra*, 15a), in 1987 the Board engaged in "the first significant substantive exertion of [its] rulemaking powers." *Id.* at 1a. The rule it ultimately issued provides that eight specific bargaining units are appropriate for all acute-care hospitals regardless of their size, location, or differences in their operation. The petitioner, American Hospital Association, successfully challenged the bargaining unit rule in the district court, which held that the Board once again had failed to follow the congressional admonition. But the court of appeals—following an approach that differed markedly from that of other courts of appeals in health care bargaining unit cases—reversed and upheld the rule.

As the National Labor Relations Board has acknowledged, this case "raises an issue of unusual public importance, for the Rule [at issue] establishes bargaining units for a major segment of the health care industry * * *." Motion for Priority Consideration In Setting Oral Argument at 3. The acute-care needs of this country are served by over 5,500 hospitals. American Hospital Ass'n, *Hospital Statistics* 202 (1989-90 ed.). Over 4,000 of those are private (*i.e.*, nongovernmental); those hospitals account for over 81% of the acute-care hospital beds in

this country. *Id.* at 20, 202. *All of them are directly affected by this case.* Unless the validity of the Board's rule is resolved now, it undoubtedly will be the subject of hospital-by-hospital litigation. Not only would that be tremendously wasteful of the resources of the courts, the Board, the hospitals, and the unions, but more importantly it would disrupt labor relations—and thus the delivery of quality patient care—throughout the nation. It is essential that this Court grant the petition and resolve the important issues it presents rather than allow them to become the subject of prolonged, disruptive and unnecessary labor strife and litigation.

1. As originally enacted in 1935, the National Labor Relations Act covered all private hospitals. But in 1947, as part of the Taft-Hartley Act, Congress amended the definition of "employer" to exclude "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." 29 U.S.C. § 152(2) (repealed, 1974). The exclusion was seen by its sponsors as necessary to "enable [nonprofit institutions] to keep the doors open and operate the hospitals." II NLRB, *Legis. Hist. of the Labor Management Relations Act, 1947* at 1464 (Reprint ed. 1985).

The Health Care Amendments Act of 1974 repealed the exemption of nonproprietary hospitals.² That Act was the

² In 1967, the Board reversed its previous position that private, proprietary hospitals were not engaged in interstate commerce and therefore were not covered by the Act. *Butte Medical Properties*, 168 NLRB 266, 268 (1967); *University Nursing Home, Inc.*, 168 NLRB 263 (1967). But because more than 80% of private hospitals are non-proprietary (see American Hospital Ass'n, *Hospital Statistics* 20), that ruling did not lead to much organizing activity among hospital employees. By bringing all private hospitals within the coverage of the Act, the 1974 statute made unionization of the hospital industry possible.

product of a legislative process that lasted two years. In 1972, a House bill that simply would have repealed the hospital exemption failed to make it out of committee in the Senate. The primary Senate opponent of the bill was Senator Robert Taft, Jr. He did not object to extending collective bargaining rights to hospital employees, but believed that the industry warranted special protection "to minimize work stoppages and to insure safe patient care." *Hearings on S. 794 Before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare*, 93d Cong., 2d Sess. 75 (1973) (hereinafter "1973 Hearings").

In 1973, Senator Taft sponsored a new bill (S. 2292) that would have designated four bargaining units as appropriate in all health care institutions: professionals, technicians, office clericals and other nonprofessionals (i.e., service and maintenance employees). *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974* (hereinafter referred to as "Leg. Hist."), at 457-458. Under the bill, the Board could not approve narrower units without the consent of the employer. *Ibid.* But Senator Taft's bill was opposed as overly rigid and unduly restrictive of the flexibility of the Board to determine health care bargaining units on a case-by-case basis taking into account the particular situation at each hospital. *Id.* at 113-114.

In light of these objections, Senator Taft introduced a compromise bill, S. 3088, that became the Health Care Amendments Act of 1974. *Leg. Hist.* at 462. The bill did not limit the Board's prescribed flexibility to determine the appropriate bargaining unit "in each case" (29 U.S.C. § 159(b)), but the sponsors agreed that the following language should appear in both the Senate and the House Reports (S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974)):

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).³

³ By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

That agreed-upon language in the legislative history, known as the "congressional admonition," expresses "Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis." *St. Francis Hospital*, 271 NLRB 948, 951 n. 17 (1984).

2. Following passage of the 1974 Act, the National Labor Relations Board determined the appropriateness of hospital bargaining units in its traditional way: through case-by-case adjudication. But as the court below found—and as the Board acknowledged in its first Notice of Proposed Rulemaking ("NPR I"), 52 Fed. Reg. 25143 (1987)—the Board's efforts were "widely regarded as a failure" (App., *infra*, 15a) and were regularly rejected by the courts of appeals, usually on the ground that the Board had failed to pay proper heed to the congressional admonition. It was against this "dismal background" (*ibid.*) that the Board decided to abandon the flexible, case-by-case approach that had been applauded by the opponents of Senator Taft's first bill and to adopt its own rigid rule.

In *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975), the Board first considered a hospital bargaining unit in the light of the congressional admonition. The Regional Director of the Board had determined that a unit

of all professionals—rather than the requested unit of registered nurses only—was appropriate. The full Board disagreed, however, and held “that registered nurses * * * are entitled to be represented for the purposes of collective bargaining in a separate unit.” *Id.* at 767. But when the Board subsequently attempted to apply this *per se* rule that registered nurses were entitled to a separate unit, the Ninth Circuit denied enforcement. *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979).

The Ninth Circuit carefully considered the legislative history of the 1974 Act, including the congressional admonition, and held that although a unit of registered nurses might be appropriate in some cases, the Board could not establish a presumption that such units are appropriate and thus dispense with the required case-by-case consideration (601 F.2d at 416):

This is not to say that a determination of a bargaining unit composed exclusively of registered nurses can never be valid. Rather, the problem lies in a rule that such a unit is always valid and its concomitant procedural quirk which excludes any consideration of evidence to the contrary. What is necessary is a demonstration, not a mere presumption, of a disparity of interests between registered nurses and other hospital employees.

Several other courts of appeals also rejected bargaining unit determinations when the Board attempted to apply presumptions that certain bargaining units were appropriate or otherwise failed to consider in each case whether the proposed unit would cause “proliferation.” See, e.g., *Long Island Jewish-Hillside Medical Center v. NLRB*, 685 F.2d 29, 34-35 (2d Cir. 1982) (“single-facility presumption * * * in the health care context” is inappropriate in light of the congressional admonition); *NLRB v. Mercy Hospital Ass’n*, 606 F.2d 22, 27-28 (2d Cir. 1979), cert. denied, 445

U.S. 971 (1980) (maintenance unit rejected because Board failed to conduct “an independent evaluation” of whether it would contribute to proliferation “in this particular hospital”); *St. Vincent’s Hospital v. NLRB*, 567 F.2d 588, 592-593 (3d Cir. 1977) (certification of separate unit of licensed boiler operators failed to heed the admonition); *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (separate unit of registered nurses requires specific explanation of how the unit comports with the admonition); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 216 (7th Cir. 1978) (Board failed to show how “its unit determination in this case implemented or reflected th[e] admonition”); *NLRB v. HMO Int’l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 809-812 (9th Cir. 1982) (Kennedy, J.) (Board improperly certified separate unit of registered nurses without evaluating whether unit would lead to proliferation; Board has “ignored a controlling legal standard” and has “openly adopt[ed] a posture of noncompliance with the will of Congress”); *Beth Israel Hospital & Geriatric Center v. NLRB*, 688 F.2d 697, 698-699 (10th Cir. 1982) (admonition precludes use of presumption that a bargaining unit is appropriate; Board must find in each case that the “units will not lead to undue proliferation at [the particular] health care facilities”); *Presbyterian/St. Lukes Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981) (reliance on presumption that a unit of registered nurses is appropriate violates the admonition).

3. The Board’s “dismal record” in the courts of appeals led it to revive its long-dormant rulemaking powers.³ Find-

³ In 1984, the Board reconsidered its approach to hospital bargaining units. In *St. Francis Hospital*, 271 NLRB at 953-954, it issued a new rule based on a “disparity of interests” standard that, in the words of the Board’s Chairman, “as a practical matter allows

(Footnote continued on following page)

ing that "[t]hirteen years and many hundreds of cases later, the Board * * * [is] no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974" (NPR I, 52 Fed. Reg. 25143), the Board concluded that it could achieve greater "judicial and public acceptance" (*id.* at 25144) of its approach to hospital bargaining units if it engaged in rulemaking to determine in advance what units were appropriate. The Board proceeded not merely to establish general guidelines, but to issue a rigid rule that eight designated bargaining units (and only those eight units) would be appropriate for every acute-care hospital in the United States, regardless of differences in size and operation. "We have decided not to make the units only 'presumptively' appropriate, because one important advantage of rulemaking is the certainty it offers." NPR I, 52 Fed. Reg. 25145.

Although the original Notice of Proposed Rulemaking distinguished between large and small facilities and provided for only six bargaining units in large hospitals and four units in small hospitals (52 Fed. Reg. 25149), the Board's final rule provides that "[e]xcept in extraordinary circumstances," the following eight "shall be appropriate units, and the only appropriate units" for all acute-care hospitals (Final Rule, 54 Fed. Reg. 16347-16348 (1989)):

³ continued

for only four units—professionals, technicals, other nonprofessionals and guards." Stephens, "The NLRB's Health Care Rulemaking: Myths versus Reality," reprinted in N. Metzger, ed., *Handbook of Health Care Human Resources Management* 405, 409 (2d ed. 1990). However, the new rule was rejected by the District of Columbia Circuit, which held (against the weight of the circuits) that the Board had paid *too much* attention to the congressional admonition. *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697, 714-715 (D.C. Cir. 1987). That decision was "the straw that broke the camel's back and prompted us to undertake rulemaking." Stephens, *supra*, at 409. See also NPR I, 52 Fed. Reg. 25143.

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All [other] nonprofessional employees * * *.

The Board made it quite clear that the "extraordinary circumstances" exception was to be extremely narrow. The Board put hospital employers on notice that it would not consider additional evidence or arguments that a particular hospital varied from the norm even if the variation is "highly unusual." Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33932-33933 (1988). "To satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate * * * the existence of * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field." *Id.* at 33933. The Board specified a long list of factors that it would not even consider as possible extraordinary circumstances.⁴

⁴ NPR II, 53 Fed. Reg. 33932. The list includes: "(1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of 'team' care, and cross-training of employees; (3) the impact of nation-wide hospital 'chains'; (4) recent changes within traditional

(Footnote continued on following page)

4. Petitioner American Hospital Association filed suit challenging the rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court held that the rule was invalid and issued a permanent injunction barring its enforcement. App., *infra*, 42a. The court "left for another day" (*id.* at 36a) the question of whether the Board's rule was precluded by the requirement of Section 9(b) of the Act that it determine the appropriate bargaining unit "in each case." 29 U.S.C. § 159(b). But it held that "[a] rule which designates an absolute number of appropriate units and mandates a particular division of the workforce * * * encourages, and perhaps coerces, fragmentation of the labor force" and thus contravenes the congressional admonition. App., *infra*, 41a-42a. The court thus found it unnecessary to reach AHA's claim that the rule was arbitrary, capricious and not supported by the evidence.

The court of appeals reversed. Citing this Court's decision in *Heckler v. Campbell*, 461 U.S. 458, 467-468 (1983), the court of appeals held that the "in each case" requirement of Section 9(b) did not require case-by-case determination of bargaining units. The court also held that the rule was not precluded by the congressional admonition. Although it found that the admonition was entitled to "consideration," the court held that Congress was concerned with "finer divisions of the health-care work force than attempted in the rule under challenge." App., *infra*, 14a.

The court of appeals also rejected AHA's claim that the rule was arbitrary and capricious particularly insofar as it failed to distinguish between "hospitals of different sizes

⁴ *continued*

employee groupings and professions, *e.g.* the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building."

and missions in different locations" (App., *infra*, 14a). The court criticized the hospital industry for failing to propose an alternative to the rule, not "respond[ing] constructively" to the Board's proposal of a six-employee minimum size for bargaining units, and "opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." *Ibid.* Without discussing any of the evidence in the record that the Board claimed supported its rule, the court below held that the rule was not arbitrary. *Id.*, at 14a-16a.

On May 2, 1990, the court of appeals granted AHA's motion to stay the issuance of the mandate pending the outcome of the petition for review in this Court.

REASONS FOR GRANTING THE PETITION

Even though the National Labor Relations Board, the AFL-CIO, the American Nurses Association, and the American Hospital Association disagree over the validity of the Board's hospital bargaining unit rule, they all recognize the enormous importance of this dispute and the far-reaching effects that the rule will have on American hospitals, their employees, and the unions that seek to represent those employees. Unless this Court grants the petition and determines whether the Board's rule is valid, it will inevitably be challenged on a hospital-by-hospital, bargaining unit-by-bargaining unit basis throughout the country. That would involve a tremendous waste of the resources of the courts, the Board, and the parties to each dispute. More importantly, it would exact a heavy toll on hospital labor relations and would thus endanger the delivery of quality patient care.

I. The Court Of Appeals' Decision That The Board's Rule Is Not Inconsistent With The "In Each Case" Requirement Of Section 9(b) Is Incorrect And Contrary To The Interpretation Of This Court And Other Courts Of Appeals

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), directs the Board to determine the appropriateness of bargaining units "in each case." As this Court has noted, the language of the statute reflects the diverse organizational needs and desires of employees and the greatly varying organization and operation of employers:

Wide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit. Congress was informed of the need for flexibility in shaping the unit to the particular case and accordingly gave the Board wide discretion in the matter. * * * The flexibility which Congress thus permitted has characterized the Board's administration of the section and has led it to resort to a wide variety of factors in case-to-case determination of the appropriate unit.

NLRB v. Hearst Publications, Inc., 322 U.S. 111, 134 (1944). The Court has thus recognized that the Board must exercise flexibility in determining bargaining units according to the facts of each particular case. *NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985); *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947).

For over 50 years—until it issued the rule at issue in this petition—the Board fulfilled its statutory obligation by determining bargaining unit questions on an individual, case-by-case basis. That is still the way the Board conducts bargaining unit determinations for all employers *other than acute-care hospitals*. As dissenting Board Member Wilford W. Johansen observed, the Board's rule

disregards the plain meaning of the statute and is inconsistent with the interpretation of the "in each case" requirement rendered by other courts of appeals. 54 Fed. Reg. 16347.

1. In its rulemaking and before the court of appeals, the Board acknowledged that Section 9(b) requires individual, case-by-case determination of bargaining unit appropriateness, but argued that the "in each case" requirement does not preclude it from adopting rules of general application. Final Rule, 54 Fed. Reg. 16338; NLRB Ct. App. Br. at 20-22. We agree that the Board could adopt through rulemaking general principles to guide the required case-by-case determinations, but the rule at issue in this petition does not merely establish general principles or rebuttable factual presumptions. By its express terms, the rule is intended to preclude any meaningful case-by-case evaluation by providing that the eight designated bargaining units "shall be appropriate units, and the only appropriate units" for acute-care hospitals "[e]xcept in extraordinary circumstances." App., *infra*, 44a. The Board made it quite clear that it views the "extraordinary circumstances" exception as so narrow as to be illusory. The Board issued a long list of factors that it would not even consider as potential extraordinary circumstances. See note 4, *supra*. And it warned that "[t]o satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field * * *." *Id.* at 33933. The Board expressly rejected the notion that it simply was establishing presumptions that those eight units were appropriate. Final Rule, 54 Fed. Reg. 16338-16339; NPR I, 52 Fed. Reg. 24145.

If, as we believe, Section 9(b) requires meaningful, individual determinations on a case-by-case basis, there can be no question that the Board's rule violates that requirement. The Board's claim that each case would receive an individual hearing is nothing more than an absurd pretense: the Board would not admit any facts about the size, location, or operations of the particular hospital but instead would routinely determine that the eight designated units are appropriate in each and every hospital. The Board has established not merely a rebuttable presumption of fact, but a presumption of law that applies even when the facts are to the contrary.

2. The "in each case" language can hardly be regarded as having no independent significance. The original draft of Section 9(b) as submitted by Senator Wagner contained all of the present language *except* the words "in each case"; those words were added quite deliberately, by amendment, and were intended to carry their plain meaning. The House Report that accompanied the version of the bill that added the "in each case" language explained that the decision of whether a bargaining unit is appropriate "is obviously one for determination in each individual case * * *." H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935), reprinted in II NLRB, *Legislative History of the National Labor Relations Act 1935* ("1935 Leg. Hist.") at 2930 (Reprint ed. 1985). See also H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935), reprinted in 1935 Leg. Hist. at 2976; H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935), reprinted in 1935 Leg. Hist. at 3072. As this Court has stated, "[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision." *Packard Motor Car Co. v. NLRB*, 330 U.S. at 491.

The court of appeals nonetheless gave three reasons for rejecting the natural interpretation (affirmed by the legis-

lative history) that Section 9(b) requires meaningful, individual bargaining unit determinations on a case-by-case basis. None of these reasons can withstand analysis.

a. First, the court of appeals held that "such interpretations are regularly rejected in decisions involving challenges to agency rules, such as the Social Security Administration's 'grid' method of deciding entitlement to disability benefits. *Heckler v. Campbell*, 461 U.S. 458, 467-468 (1983)." App., *infra*, 6a. But the statute involved in *Campbell* did not include any language analogous to the "in each case" requirement of Section 9(b). Moreover, this Court upheld the rule involved in *Campbell* because it involved "an issue that is not unique to each claimant." 461 U.S. at 468. The Court merely held that an "agency may rely on its rulemaking authority to determine issues that *do not require case-by-case consideration*." *Id.* at 467 (emphasis added). By contrast, bargaining unit determinations *do* involve issues that are unique to each employer. By their nature and by the language of the statute they *do* require case-by-case determination.⁵

A closer look at the *Campbell* decision and the rules at issue in that case actually supports AHA's position that the Board's bargaining unit rules are invalid. The Social Security Act requires the Secretary of Health and Human Services to make a two-part determination. As the Court explained (461 U.S. at 467-468):

⁵ In upholding the regulations in *Campbell*, the Court relied on its previous decisions in *Federal Power Comm'n v. Texaco, Inc.*, 377 U.S. 33, 40 (1964), and *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). But the Court was careful to emphasize that in those cases—as in *Campbell*—"an individual applicant [was allowed] to show that the rule promulgated should not be applied to him." 461 U.S. at 467 n.11. In this case, however, the Board has foreclosed that possibility by making it clear that the rule applies in *all* cases, except in the rare instance where there are "extraordinary circumstances" warranting a different result.

[The Secretary] must assess each claimant's individual abilities and then determine whether jobs exist that a person having the claimant's qualifications could perform. The first inquiry involves a determination of historic facts, and the regulations properly require the Secretary to make these findings on the basis of evidence adduced at a hearing. We note that the regulations afford claimants ample opportunity both to present evidence relating to their own abilities and to offer evidence that the guidelines do not apply to them. The second inquiry requires the Secretary to determine an issue that is not unique to each claimant—the types and numbers of jobs that exist in the national economy.

The issues that the Board's rule conclusively determines are like the issues involved in the *first* part of the disability determination: they are matters of historic fact, unique to each hospital. The question of whether a particular bargaining unit is appropriate to a particular hospital (and the question of whether the unit would cause proliferation) involves such issues as the size, location, staffing patterns and operation of the hospital, the degree of functional integration of the workforce, and so on—all unique factual matters that the Board no longer will even consider. NPR II, 53 Fed. Reg. 33932. It is simply nonsensical to regard these issues as analogous to the national availability of jobs issue that the Court held could be determined by rulemaking.

b. The court of appeals also reasoned that the "in each case" language was intended to prevent the Board from siding with either "of the two major labor federations, the AFL and the CIO—the former a federation of craft unions, the latter of plant unions." App., *infra*, 7a. The court stated that "[i]f the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically. The 'in each case' proviso forbids the Board to do this." *Ibid*.

But the "in each case" language and the entire Act predates the dispute between the AFL and the CIO. The language was added to the Wagner bill in May 1935, and the NLRA was passed the next month. The CIO was formed initially as a committee within the AFL after the AFL convention in October 1935, and did not break away as a separate federation until 1938. As a leading historian of the Act has commented, "[n]one of the draftsmen [of the Wagner Act] foresaw the cleavage in the union movement that appeared later in 1935." I. Bernstein, *The New Deal Collective Bargaining Policy* 96 (1950).⁶

c. The court of appeals' third reason was that it construed the legislative history (including the statement that the appropriateness of a bargaining unit "is obviously [a matter] for determination in each individual case") to mean only "that unit determination is a task meet for the Board rather than for either the Congress or the employees themselves." App., *infra*, 7a-8a. In addition, the court concluded that if Congress had meant the "in each case" language to preclude the kind of rulemaking the Board has undertaken, "it is probable (no stronger statement is possible) that Congress would have made an explicit exception for unit determination" in Section 6 of the Act, which gives the Board rulemaking authority. *Id.* at 8a. Both assertions are incorrect.

To begin with, the statement in the legislative history that the question of whether a bargaining unit is appropriate "is obviously one for determination in each individual case" clearly relates to how bargaining units should be determined, and not to who should make that determination. That statement explains the "in each case"

⁶ See also I. Bernstein, *The Turbulent Years* 400-402, 697-698 (1970); W. Galenson, *The CIO Challenge to the AFL* 3 (1960) ("November 9, 1935 [is] the date usually given as the birthday of the CIO").

language, not the allocation of responsibility for the determination to the Board. This conclusion follows not just from a commonsense reading of Section 9(b) and the passage from the various House Reports, but also from a comparison of those reports with Senate Report No. 573, which was published before the bill was amended to add the "in each case" language. S. Rep. No. 573, 74th Cong., 1st Sess. (1935), reprinted in 1935 *Leg. Hist.* 2300. Like the later House Reports, S. Rep. No. 573 discusses the allocation of responsibility and indicates that the Board rather than the employees must determine the appropriateness of bargaining units. *Id.* at 14, 1935 *Leg. Hist.* 2313. But it says nothing about the issue being "obviously one for determination in each individual case." That language appears in the legislative history for the very first time in the House Report (No. 969) issued immediately after Section 9(b) was amended to add the "in each case" language.

Nor is it "probable" that Congress would have amended Section 6 to make it clear that bargaining unit determinations could not be performed by rulemaking. Congress *did* include an "explicit exception for unit determination"; that exception is the "in each case" language of the subsequent Section 9(b). It simply would have been redundant to repeat the specific exception of Section 9(b) within the more general rule of Section 6. Moreover, it requires a perversion of the canons of statutory construction to argue that the general language of Section 6 overrides the specific language of Section 9(b).⁷

⁷ In *Heckler v. Campbell* this Court noted that the determination of a disability claimant's abilities required an individual, case-by-case determination. 461 U.S. at 467-468. Yet the Social Security Act gives the Secretary broad rulemaking powers and does not specifically state that those powers do not apply to the Secretary's determination of an individual claimant's abilities. See 42 U.S.C. § 405(a).

3. The court of appeals' interpretation of the "in each case" language cannot be reconciled with the interpretation of that same language by other courts of appeals. Those courts have given full effect to the "in each case" requirement and have required the Board to make individual, case-by-case determinations of whether a bargaining unit was appropriate.

One context in which the courts of appeals have enforced the plain meaning of the "in each case" language has been in rejecting the Board's reliance on prior state agency determinations of bargaining unit appropriateness. In *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 360 (3d Cir. 1976), the Third Circuit held that the Board could not accept a state agency's determination that a bargaining unit was appropriate because to do so would be an abdication of the requirement of individual, case-by-case determination by the NLRB:

Congress has thus mandated Board determination "in each case" of "the unit appropriate" for collective bargaining. Thus the statute requires the Board to exercise its discretion as to an appropriate unit in each and every case.

See also *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979). The Second Circuit reached the same conclusion in *Long Island College Hospital v. NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), cert. denied, 435 U.S. 996 (1978). Similarly, in *NLRB v. Cardox Div. of Chemetron Corp.*, 699 F.2d 148, 155-156 (3d Cir. 1983), the court held that the "in each case" language precluded the Board's reliance on the parties' prior agreement that a unit was appropriate.

The issue has also arisen in another context, in which the courts of appeals have rejected the Board's attempts to apply conclusive (or nearly conclusive) presumptions that certain types of bargaining units are appropriate. For example, in *Big Y Foods, Inc. v. NLRB*, 651 F.2d 40 (1st

Cir. 1981), the court of appeals upheld the Board's determination that a separate bargaining unit for the meat department of a grocery chain was appropriate. In discussing the Board's power to decide the appropriate unit, the First Circuit noted that the "in each case" language required individual, case-by-case determinations and precluded reliance on irrebuttable presumptions that certain units are correct (651 F.2d at 45-46; citations omitted):

The only pertinent limitation [on the Board's powers] is the §9(b) statutory direction to the NLRB to make a decision "in each case." It has been held that that statutory direction invalidates a conclusive presumption because it precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees. But that statutory direction does not invalidate a rebuttable presumption which has no preclusive effect.

See also *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 638 (2d Cir. 1983); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 416; *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980). Indeed, in *Newton-Wellesley*, the Board itself acknowledged the effect of the "in each case" language:

We have concluded that so much of the Board's *St. Francis* decision as may be read to establish an irrebuttable presumption of the appropriateness of registered nurse units in all cases, without regard to particular circumstances, should be disavowed. Such a *per se* approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide "in each case" whether the requested unit is appropriate.

Ibid. (emphasis added). See also *St. Francis Hospital*, 265 NLRB at 1028.

The court of appeals' decision to disregard the plain meaning of the "in each case" requirement thus is contrary to the statute and impossible to reconcile with the

approach taken by other courts. This Court should grant the petition and make it clear that Section 9(b) of the Act requires individual, case-by-case determinations of bargaining units.

II. The Court Of Appeals' Decision That The Board's Rule Does Not Contravene The Congressional Admonition Is Incorrect And Contrary To The Decisions Of Other Courts Of Appeals

The Board's rule not only is contrary to the express language of Section 9(b), but it is also inconsistent with the Health Care Amendments Act of 1974 and with the admonition contained in both the House and Senate Reports requiring the Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." App., *infra*, 8a.⁸ Other courts of appeals have interpreted that statute to require case-by-case bargaining unit determination in the health care industry and to prohibit the Board from establishing binding presumptions of law that particular units are appropriate. The Seventh Circuit's decision in this case reaches precisely the opposite conclusion. That conflict among the courts of appeals on this important question of statutory construction by itself would require review.

But even without a circuit conflict, this case clearly warrants review. Ironically, the result of the court of appeals' decision is that, despite the congressional admonition that special care be taken in evaluating bargaining units in the health care industry, that industry has now become the *only* one as to which the Board does not provide meaningful, case-by-case determination of bargaining

⁸ As this Court has repeatedly recognized, the House and Senate Committee Reports are the most authoritative source for determining congressional intent. *Thornburg v. Gingles*, 478 U.S. 30, 43 n.7 (1986); *Garcia v. United States*, 469 U.S. 70, 76 (1984); *Zuber v. Allen*, 396 U.S. 168, 186 (1969).

unit issues. Instead of taking special care in cases involving the health care industry, the Board proposes to eliminate its traditional, case-by-case approach and to take no particularized care at all in that industry.

The Board has candidly acknowledged that the rule is based on its finding that Congress was wrong when it issued the admonition against proliferation of bargaining units:

The legislative history showed "proliferation" was opposed by Congress because it was feared that [it] would lead to numerous work stoppages, jurisdictional disputes, and wage whipsawing and leapfrogging. However, as was amply documented in NPR II, multiple units have not been shown to cause an unusual number of work stoppages, nor have they been shown to have caused jurisdictional disputes, wage whipsawing or leapfrogging. * * * [T]he evidence presented to us is that there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.

Final Rule, 54 Fed. Reg. 16346. Of course, the Board's "finding" ignores the fact that there has *not* been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach. Had there been a proliferation of units, the Board then might have been able to examine its impact, but its "finding" of no impact at this point is sheer speculation. In any event, an administrative rule of great importance, that is based not on the agency's desire to carry out the will of Congress but on its finding that Congress was misguided warrants review by this Court.

1. The court of appeals held that the congressional admonition against proliferation of bargaining units "is entitled to our respectful consideration, not only for its intrinsic merits but also for what light it sheds on Congress's intentions in the 1974 amendments." App., *infra*, 12a. Because the 1974 Act applied the provisions of the National Labor Relations Act (including Section 9(b)) to

most private hospitals for the first time, the court found that the admonition should be regarded "as equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action." *Ibid.* Nevertheless, the court below declined to follow the lead of the Ninth and Tenth Circuits and instead held that the statute as interpreted in light of the admonition did *not* preclude the Board from adopting a rule that specific bargaining units would be presumed as a matter of law to be appropriate in each and every acute-care hospital in the country.

Although the Board's decision to engage in rulemaking was historic, the rule itself provides nothing new. The rule establishes eight bargaining units that are quite similar to the units the Board initially designated as appropriate in the years following enactment of the Health Care Amendments Act. *St. Francis Hospital*, 265 NLRB 1025, 1029 (1982); *Allegheny General Hospital*, 239 NLRB 872, 888 (1978) (Member Penello, dissenting). See C. Morris, *The Developing Labor Law* 438 (1983).⁹ And from early on, the Board asserted—as it does in the rule—that at least some of those units (particularly registered nurses) were to be considered appropriate "*per se*" and that evidence to the contrary would not be considered. *Mercy Hospitals*, 217 NLRB at 767; *Methodist Hospital of Sacramento, Inc.*, 223 NLRB 1509 (1976). It was that very approach—the same approach now embodied in the Board's rule—that was repeatedly rejected by the courts of appeals.

⁹ See also *Ohio Valley Hospital Ass'n*, 230 NLRB 604 (1977) (physicians); *Mercy Hospitals*, 217 NLRB at 770-771 (separate units of registered nurses, service and maintenance employees, and office clericals); *Newington Children's Hospital*, 217 NLRB 793 (1975) (service and maintenance unit); *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975) (technical employees); *Peninsula Hospital Center*, 219 NLRB 139 (1975) (guards).

In *NLRB v. St. Francis Hospital of Lynwood*, the Board applied the *Mercy Hospital* rule that a unit of registered nurses would be regarded as *per se* appropriate for all hospitals. The Board refused to consider evidence proffered by the hospital that the bargaining unit should include all professionals, stating that under its announced rule, the nurses unit was conclusively presumed to be appropriate. 601 F.2d at 407-408. The Ninth Circuit denied enforcement, holding that the Board's rule was contrary to "the congressional directive that the Board give 'due consideration' to preventing undue proliferation of bargaining units in the health care industry and Congress's expressed approval of the trend toward broader units in this area." *Id.* at 414. The court of appeals agreed that a unit of registered nurses ordinarily might be valid, but held that a rule that created a legal presumption that such a unit always was appropriate and that restricted the ability of the employer to offer evidence that the unit was not appropriate in a particular situation was contrary to the statute and to the admonition against proliferation. *Id.* at 416.

The Tenth Circuit reached the same conclusion in *Presbyterian/St. Lukes Medical Center v. NLRB*, 653 F.2d at 457. See also *Beth Israel Hospital & Geriatric Center v. NLRB*, 677 F.2d 1343, 1345 (10th Cir. 1981), modified in other respects, 688 F.2d 697 (10th Cir.). And the Second Circuit, in upholding a unit of service and maintenance workers, indicated that "the Board would abuse its discretion were it to make a unit determination in the health care field solely on the basis of a presumption of appropriateness. * * * [I]n the health care field, the Board must specify how its unit determination implements or reflects the congressional admonition. * * * The Board is committed to evaluating each unit petition on the facts." *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d at 638.

The Board rule involved in this case is identical in all relevant respects to the rule rejected by the Ninth and Tenth Circuits. The rule creates a binding presumption of law that the eight units are appropriate in every hospital and prohibits employers from introducing evidence to show that a particular unit is not appropriate. NPR II, 53 Fed. Reg. 33932-33933. If a union acting under the Board's new rule petitioned to represent the registered nurses at Mercy Hospital or Presbyterian/St. Lukes Medical Center, the Board again would hold that the unit was appropriate *per se* and again would preclude the hospitals from offering evidence to the contrary. In light of their prior decisions holding that the Board must give employers a meaningful opportunity to present evidence that the unit is inappropriate to that particular hospital, there is absolutely no reason to believe that the Ninth or Tenth Circuits would now uphold the Board's application of its new rule.

In opposing the AHA's motion for a stay of the mandate, the Board argued that there was no conflict with the Seventh Circuit's decision because the Ninth and Tenth Circuits had "essentially held" that the Board had not provided "an adequate empirical basis" for its rule. Opposition Of The National Labor Relations Board To Plaintiff-Appellee's Motion For Stay Of Mandate, at 4 n.2. There is nothing in either of those courts' opinions to support that contention. To the contrary, in *St. Francis Hospital of Lynwood*, the Ninth Circuit specifically noted that even if the Board had previously established presumptions based on adequate evidence, it would still be required to give the hospital in the particular case where the presumptions were applied "the opportunity to effectively present evidence to rebut the presumptions." 601 F.2d at 416. And in *Presbyterian/St. Lukes Medical Center*, the Tenth Circuit went even further,

holding that “any use of a presumption which casts upon the Medical Center the burden of producing evidence of the inappropriateness of the unit violates Congress’ directive of nonproliferation in the health care industry. * * * [T]he Board must specify ‘the manner in which its unit determination *in this case* implement[s] or reflect[s] that admonition.’ ” 653 F.2d at 457 (emphasis added). Thus, the conflict among the circuits is clear and requires this Court’s resolution.¹⁰

III. The Board’s Rule Is Arbitrary And Capricious And Not Supported By Substantial Evidence Insofar As It Ignores Critical Differences Among Hospitals

Even if the language and legislative history of the NLRA permitted the Board to establish bargaining units based on conclusive presumptions, the Board’s rule would still be arbitrary, capricious, and not supported by substantial evidence insofar as it ignores critical differences among hospitals, including differences in size, location, and operations. Although the district court found it unneces-

¹⁰ The courts of appeals are also in conflict over the more general issue of the effect to be given to the congressional admonition. Most of them have held that the admonition is binding and prohibits the Board from applying its traditional unit determination criteria in cases involving the health care industry. See, e.g., *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d at 632 (2d Cir.); *NLRB v. HMO Int’l/California Medical Group Health Plan, Inc.*, 678 F.2d at 808 (9th Cir.); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 412 (9th Cir.); *St. Anthony’s Hospital Systems, Inc. v. NLRB*, 884 F.2d 518, 519-520 & n.3 (10th Cir. 1989).

The District of Columbia Circuit, on the other hand, has held that the congressional admonition has virtually no binding effect on the Board. *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d at 712. The Seventh Circuit in this case struck an intermediate position, holding that the admonition is entitled to some “respectful consideration” but that it is not binding “as if it were a statute.” App., *infra*, 12a.

sary to reach this issue, the court of appeals—without any detailed examination of the evidence in the record—held that the rule was not arbitrary.

The court of appeals characterized AHA’s argument that the rule improperly lumped together hospitals of greatly differing size, missions and locations as “an important criticism.” App., *infra*, 14a. Nevertheless, it refused to strike down the rule on that ground because the hospital industry had failed to propose alternatives or to seek modification of the Board’s rule (*ibid.*):

This is an important criticism but it would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of a rule. * * * Another way in which the industry failed to respond constructively to the Board’s desire to bring unit determination in the acute-care hospital industry under a rule was by failing to press for an increase in the six-employee minimum [for employees in a unit].

The relevant issue, however, is *not* whether petitioner offered and supported a reasonable alternative, but whether the Board’s rule was arbitrary, capricious, or not supported by substantial evidence. 5 U.S.C. § 706(2)(A), (E). The court of appeals failed seriously to examine that issue.

Had the court of appeals looked more closely at the record, it would have found that the evidence supports only one conclusion: that the differences among hospitals are so great as to make any blanket rule arbitrary. The Board claimed at several points that its experience in handling hundreds of hospital bargaining unit cases over 13 years demonstrated that all such facilities were “remarkably uniform” and “virtually identical.” NPR I, 52 Fed. Reg. 25143-25145; NPR II, 53 Fed. Reg. 33932-33933. But the Board itself acknowledged just five years before that “[the] diverse nature of today’s health care industry

* * * precludes any generalization as to the appropriateness of any particular bargaining unit." *St. Francis Hospital*, 271 NLRB 948, 953 n.39 (1984). A close examination of the evidence in the record would confirm that the Board's earlier assessment was correct. In health care, as in other industries, "wide variations [and] complexities of modern industrial organization [preclude] the use of inflexible rules as the test of an appropriate unit." *NLRB v. Hearst Publications, Inc.*, 322 U.S. at 134.

Absent evidence that the health care industry had changed radically over the past five years—and there was no such evidence in the record—the Board's new and drastically altered "finding" warranted more thorough analysis than that provided by either the Board or the court below. *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 42 (1983).

IV. The Court Of Appeals' Decision Raises Issues Of Great National Consequence That Need To Be Resolved By This Court

The importance of this case to the delivery of health care in the country—and to millions of hospital employees—cannot be overestimated and has been acknowledged by all of the parties. The NLRB stated in the court of appeals that AHA's challenge to the validity of the rule "raises an issue of unusual public importance, for the Rule establishes bargaining units for a major segment of the health care industry * * *." Motion For Priority Consideration In Setting Oral Argument at 3. The AFL-CIO also believes that it is essential to obtain "a *speedy* resolution of the industry's challenge to the validity of the Rule" (AFL-CIO Memorandum In Support Of Motion To Intervene at 6) because "only a decision by the U.S. Supreme Court will put an end to the protracted litigation in this area." "Unions Want NLRB to Jump the Gun on Bargain-

ing Units," *Modern Healthcare*, Nov. 25, 1988, at 33. Similarly, when AHA indicated that it planned to seek review in this Court, a spokesperson for the American Nurses Association remarked that "[a]ll the parties have expected Supreme Court review of the rulemaking process." Bureau of National Affairs, *Daily Labor Report* A-14 (April 26, 1990).

In AHA's view—based on the experience of its 5,500 member hospitals—the Board's designation of eight bargaining units in each and every acute-care hospital licenses the very proliferation of units that Congress sought to preclude. The rule would increase the number and severity of strikes and the use of tactics such as "whipsawing" and "leapfrogging" by hospital unions. It thus not only would disrupt the delivery of health care, but also would significantly increase its cost at a time when escalating health care expenses are a pressing national problem. We do not expect the Board or the union respondents to agree that the rule would have such a disastrous impact,¹¹ but their expenditure of enormous resources on the rule-making process testifies to their perception of the importance of the rule.

As lawyers in the health care field already have promised, the alternative to review in this Court would be case-by-case, hospital-by-hospital challenges to bargaining unit determinations:

[H]ospitals are entitled to challenge the rules in 47 other states. "Until the Supreme Court ultimately passes on the validity of the unit determination rules . . . we will proceed in our clients' representation cases in precisely the same way as we have done so in the past."

¹¹ Indeed, the Board's rule is based on its express finding that Congress was misguided in its concerns about unit proliferation. Final Rule, 54 Fed. Reg. 16346.

Statement of hospital attorney Roger King, reported in *Modern Healthcare*, April 23, 1990, at 3.

Review by this Court is essential not merely to prevent the disruption of health care and the increase in hospital costs that AHA believes will be caused by implementation of the Board's rule, but also to prevent the disruption and costs that surely will be caused by allowing the validity of the rule to become the subject of hospital-by-hospital wrangling and litigation around the country. It is time to get the matter finally resolved.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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July 1990

APPENDIX

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Nos. 89-2604, 89-2605, 89-2622

AMERICAN HOSPITAL ASSOCIATION,

Plaintiff-Appellee,

v.

NATIONAL LABOR RELATIONS BOARD, JAMES M.
STEPHENS, MARY M. CRACRAFT, JOHN E. HIGGINS, JR.,
DENNIS M. DEVANEY, AND JOHN C. TRUESDALE,

Defendants,

and

AMERICAN NURSES ASSOCIATION, AMERICAN
FEDERATION OF LABOR AND CONGRESS OF
INDUSTRIAL ORGANIZATIONS, AND BUILDING
AND CONSTRUCTION TRADES DEPARTMENT,
AFL-CIO,

Intervening Defendants-Appellants.

ARGUED JANUARY 10, 1990—DECIDED APRIL 11, 1990

Before POSNER, RIPPLE, and KANNE, *Circuit Judges.*

POSNER, *Circuit Judge.* The National Labor Relations Board, joined by intervening unions, appeals from an order by the district court enjoining the first significant substantive exertion of the rulemaking powers conferred on the Board, almost half a century ago, by section 6 of the National Labor Relations Act, 29 U.S.C. § 156. By "substantive," we mean other than jurisdictional, procedural, or remedial.

Section 9(b) of the Act, 29 U.S.C. § 159(b), directs the Board to determine in each case the appropriate unit for collective bargaining. The rule that the district court enjoined provides that, save in extraordinary circumstances, the Board will recognize the following, and only the following, eight bargaining units for employees of acute-care hospitals: physicians, registered nurses, other professional employees, medical technicians, skilled maintenance workers, clerical workers, guards, and other nonprofessional employees. *Collective-Bargaining Units in the Health Care Industry*, 52 Fed. Reg. 25142 (1987) (notice of rulemaking), 53 Fed. Reg. 33900 (1988) (further notice), 54 Fed. Reg. 16336 (1989) (final rule), enjoined, 718 F.Supp. 704 (N.D. Ill. 1989). No unit, however, will be certified that has fewer than six employees. The rule is limited to acute-care hospitals, but does not differentiate among them by size or location except insofar as the six-employee minimum may prevent the formation of all eight units in the smallest hospitals. Section 9(b) itself entitles guards to form their own separate unit, 29 U.S.C. § 159(b)(1), so we may assume that the six-employee minimum does not apply to guards (the Board's rule is silent on the question). But a hospital would still have to have a minimum of 43 employees for all eight bargaining units to be recognized in it—one guard plus six employees in each of the other seven units. The statute also entitles professional employees to bargain separately from nonprofessional employees, 29 U.S.C. § 159(b)(1), but there will always be more than six professional employees in a hospital or other facility covered by the rule.

The hospital industry objects to any rule that requires the recognition of more than the statutory minimum of three units—professional employees, guards, and other nonprofessional employees. Which is to say that it objects to any rule at all, since no rule is necessary to confer rights already conferred by the statute.

Labor and management are perennially and systematically at odds over the appropriate number of bargaining units. *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1468-71 (7th Cir. 1983); *Continental Web Press, Inc. v. NLRB*, 742 F.2d 1087, 1090 (7th Cir. 1984); Note, *The National Labor Relations Board's Proposed Rules on Health Care Bargaining Units*, 76 Va. L. Rev. 115, 117-18, 121-122 (1990). From organized labor's standpoint, generally the more units there are the better. This is because the smaller and more homogeneous a bargaining unit is, the easier it will be for the members to agree on a mutually advantageous course of collective action, and therefore the more attractive a union will be, unionization being the vehicle for collective action by employees. By the same token, the larger and more heterogeneous the unit is, the harder it will be for the members to agree on a common course of action. The diversity of, often amounting to conflict between, the interests of the members of a large and heterogeneous unit will make collective action difficult, so it will be hard for a union to gain majority support in such a unit or, having gained it, to use it to bargain effectively (for example, by making a credible threat to strike). This is the union's perspective; the employer's perspective is different. The more units there are, the more costly it will be for the employer to negotiate collective bargaining contracts. And work stoppages will be likelier, because there will be more separate decision-making centers each of which can call a strike, and because majority support for a strike call is more likely the more homogeneous a unit is and hence the likelier all members are to benefit if the union wins.

In making unit determinations the Board is thus required to strike a balance among the competing interests of unions, employees (whose interests are not always identical with those of unions), employers, and the broader

public. The statute, though otherwise nondirective, can be read to suggest that the tilt should be in favor of unions, and hence toward relatively many rather than relatively few units. *NLRB v. Res-Care, Inc.*, *supra*, 705 F.2d at 1469; but see 29 U.S.C. § 159(c)(5); *Continental Web Press, Inc. v. NLRB*, *supra*, 742 F.2d at 1090-91. The statute states: "The Board shall decide in each case whether, *in order to assure to employees the fullest freedom in exercising the rights guaranteed by* [the National Labor Relations Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." 29 U.S.C. § 159(b) (emphasis added). It is true that among the rights that the Act explicitly confers on workers is the right not to organize. 29 U.S.C. § 157. But even with the Taft-Hartley amendments this is not the *principal* right of workers under the National Labor Relations Act. The principal purpose of the Act was and is to protect workers who want to organize for collective bargaining.

In any event, the precise balance among the competing interests is certainly not spelled out in the statute; it is for the Board to decide. *NLRB v. Res-Care, Inc.*, *supra*, 705 F.2d at 1469; *Continental Web Press, Inc. v. NLRB*, *supra*, 742 F.2d at 1090. The decision is particularly difficult and delicate in the health care industry because the work force of a hospital (or nursing home or rehabilitation center) tends to be at once small and heterogeneous. It may include physicians, registered nurses, psychologists, licensed practical nurses, nurses' aides, lab technicians, orderlies, physical therapists, dieticians, cooks, guards, clerical workers, maintenance workers, guards, and others—but often only a few of each. If the desirability (from the union standpoint) of homogeneous units is stressed, even a hospital of average size might have ten or twenty or even more units, each with a bare handful of workers.

The cost of the institution's labor relations and the probability of work stoppages would soar. Wages might soar too (depending of course upon competition among hospitals), since proliferation of units fosters unionization and a principal objective of unions is to raise their members' wages. But this is far from certain; workers do not receive wages when they are on strike, and strike-prone workers are worth less to employers.

Work stoppages, heavy bargaining costs, soaring wages, labor unrest—all these are matters of concern in a period of high and rising costs of health care, and indeed, as we shall see, commanded congressional attention even before the tide came in. The sorting out and weighing of these matters are judgmental functions committed to the Board.

The Board's rulemaking power is explicit and broad. Section 6 provides: "The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of [the National Labor Relations Act]." (The reference to the APA was added in 1947; the rest of the provision dates back to the original Act.) The industry does not argue that the power is confined to nonsubstantive matters or has atrophied from disuse, and there is broad although not unanimous agreement in the legal community, which we and other courts have remarked approvingly, that the exercise of the Board's dormant substantive rulemaking power is long overdue. *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 765 n.3 (1969); *id.* at 769-80 (concurring opinion); *NLRB v. Res-Care, Inc.*, *supra*, 705 F.2d at 1466; *Continental Web Press, Inc. v. NLRB*, *supra*, 742 F.2d at 1093-94; *NLRB v. Majestic Weaving Co.*, 355 F.2d 854, 859-61 (2d Cir. 1966) (Friendly, J.); *International Union of Operating Engineers v. NLRB*, 353 F.2d 852, 856 n.16 (D.C. Cir. 1965); Peck, *A Critique of*

the National Labor Relations Board's Performance in Policy Formulation, 117 U. Pa. L. Rev. 254 (1968); Morris, *The NLRB in the Dog House*, 24 San Diego L. Rev. 9, 27-42 (1987); Shapiro, *Why Do Voters Vote?*, 86 Yale L.J. 1532, 1543-45 (1977); cf. *Mosey Mfg. Co. v. NLRB*, 701 F.2d 610, 612 (7th Cir. 1983) (en banc); but see Williams, *The NLRB and Administrative Rulemaking*, 16 Inst. Labor L. 209 (1970). We are speaking of explicit rulemaking; the Board also of course has long made rules in common law fashion, case by case, and its power to make rules this way is no longer open to doubt. *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 290-95 (1974). Its rulemaking power is not less when it proceeds, under the explicit authority of section 6, in accordance with the procedures that the Administrative Procedure Act prescribes for rulemaking.

There is, however, a question whether the Board is authorized to make a rule recognizing eight separate bargaining units in the acute-care hospital industry. The district judge thought not, and the industry defends his conclusion on three separate grounds. The first is based on the text of section 9(b): "The Board shall decide [the appropriate unit] *in each case*" (emphasis added), implying the industry argues, that the Board must determine the appropriate unit on a case by case basis, except for the irreducible minimum of three units authorized by the statute itself. We do not interpret the statute so, and note that such interpretations are regularly rejected in decisions involving challenges to agency rules, such as the Social Security Administration's "grid" method of deciding entitlement to disability benefits. *Heckler v. Campbell*, 461 U.S. 458, 467-68 (1983). The reference in section 9(b) to employer, craft, and plant units suggests that the term "in each case" was included to prevent the Board from bringing about a revolution in unit determinations by pre-

scribing employer units, or craft units, or plant units for all employers under the Board's jurisdiction. At the time the Wagner Act was passed, there was an enormous diversity of bargaining units, in major part reflecting the different characters of the two major labor federations, the AFL and the CIO—the former a federation of craft unions, the latter of plant unions. If the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically. The "in each case" proviso forbids the Board to do this. But it is consistent with the background and semantics of the proviso that a "case" can be an industry or (as here) a subset or submarket of an industry; it need not be a particular dispute between a particular employer and a particular union at a particular plant or establishment.

Another possibility is that "in each case" simply expresses the truism that, whether or not the Board proceeds by formal rulemaking, it still must determine the bargaining units in each case in which there is a dispute over how to classify particular workers. In other words, a rule, like a statute, is applied case by case. Still another possibility is that "case" means "proceeding" in a sense broad enough to cover a rulemaking proceeding as well as an adjudicative one.

The legislative history of "in each case" is scanty, but the House Reports do say that "section 9(b) provides that the Board shall determine . . . [the appropriate unit]. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination." H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935); H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935). In context, all this appears to mean is that unit determination is a task meet for the

Board rather than for either the Congress or the employees themselves. And since three sections earlier in the National Labor Relations Act, in a provision (section 6) enacted at the same time as section 9(b), Congress had granted the Board explicit rulemaking power, it is probable (no stronger statement is possible) that Congress would have made an explicit exception for unit determination if it had wanted to place that determination outside the scope of the Board's rulemaking power.

The industry makes no argument that unit determination is inherently less suitable for rulemaking than any of the other dimensions of labor relations regulated by the Board. Nor is the procedure the Board has followed the focus of the industry's challenge; the industry would have objected just as vigorously if the Board had announced the rule in an adjudicative proceeding, as it has announced virtually all of its substantive rules until this one. The broad discretion that the statute grants the Board in the matter of unit determination is an invitation to the Board to bring order out of chaos through rules, and rulemaking is often and perhaps here a superior method of making rules than adjudication is. Since there is no reason why Congress might have wanted to carve out unit determinations from the grant of rulemaking power in section 6 and no indication beyond the ambiguous semantics of the word "case" that it did want to do this, we conclude that unit determinations is not excepted from the Board's power under that section.

The second ground on which the industry urges us to uphold the injunction is that the Board's rule is inconsistent with the following statement in the congressional committee reports accompanying the Health Care Amendments Act of 1974:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Commit-

tee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).¹

S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). (The footnote states: "By our reference to *Extendicare* we do not necessarily approve all of the holdings of that decision.") The background and application of this passage are discussed exhaustively in the majority and concurring opinions in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), allowing us to be brief.

Before the 1974 amendments, nonproprietary (i.e., non-profit) hospitals—which dominated the hospital industry then even more than they do now—were not subject to the Board's jurisdiction, and, possibly as a result, there was little union activity in the hospital sector. Naturally the industry opposed the extension of the Board's jurisdiction to the nonproprietarys, but not having the muscle to defeat the extension focused its efforts on securing provisions to require ten-day advance notice of strikes and to limit the number of bargaining units (one proposal was to limit the number to four). Union interests opposed both provisions. The result of the collision of interest groups was a compromise whereby advance notice of strikes was required, 29 U.S.C. § 158(g); *East Chicago Rehabilitation Center, Inc. v. NLRB*, 710 F.2d 397, 401-04 (7th Cir. 1983), but no change was made in the unit-determination statute. However, the industry did succeed in persuading the members of the House and Senate committees to include in the committee reports the admonition concerning unit proliferation that we have quoted.

Ordinarily a committee report that is not explaining new or altered statutory language has little significance in the interpretation of a statute. *Public Employees Retirement System v. Betts*, 109 S. Ct. 2854, 2861 (1989). Suppose a congressional committee issued a report expressing disagreement with a decision by the Supreme Court interpreting a provision of the Sherman Act unchanged since 1890. The report might be a persuasive document by virtue of the cogency of its reasoning but it would have no legislative significance. Congress legislates by passing bills and sending them to the President for his signature. It does not legislate by issuing committee reports. *Prussner v. United States*, 896 F.2d 218, 228 (7th Cir. 1990) (en banc); *In re Sinclair*, 870 F.2d 1340 (7th Cir. 1989). Post-enactment legislative history (an oxymoron—the history of an event lies in its past, not its future) is sometimes a sneaky device for trying to influence the interpretation of a statute, in derogation of the deal struck in the statute itself among the various interests represented in the legislature. *Covalt v. Carey Canada Inc.*, 860 F.2d 1434, 1438-1439 (7th Cir. 1988); *In re Tarnow*, 749 F.2d 464, 467 (7th Cir. 1984). Courts must be careful not to fall for such tricks and thereby upset a legislative compromise.

If, however, Congress does enact a statute, the committee reports explaining it may have considerable significance in guiding interpretation. We say this fully aware that a growing number of judges disagree. They regard committee reports (and *a fortiori* the rest of legislative history—hearings and rejected bills and floor debate) as illegitimate efforts to influence judicial interpretation. We reviewed this skeptical literature in *In re Sinclair*, *supra*, 870 F.2d at 1343-44, but we did not endorse it, noting that “clarity depends on context, which legislative history may illuminate.” *Id.* at 1342. The expressed purposes of the drafters of statutory language can assist in interpreta-

tion, especially of ambiguous language. Sometimes a committee report is designed to give a statute a spin not intended by a majority of the Congress that enacted it or by the President that signed it, *Green v. Bock Laundry Machine Co.*, 109 S. Ct. 1981, 1994 (1989) (concurring opinion); *Hirschey v. FERC*, 777 F.2d 1, 7 n.1 (D.C. Cir. 1985) (concurring opinion), but the extent of this abuse remains unclear. For divergent views on its prevalence, see Judges and Legislators: Toward Institutional Comity 170-75 (Katzmann ed. 1988). Judges should be alert to the possibility of abuse, but should also be careful not to throw out the baby with the bathwater.

The admonition in the 1974 committee reports is certainly not a statute, *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980) (dissenting opinion), and courts that have treated it as such have in our view erred. (The dissent thought the majority had done that in *Mary Thompson*, but we do not read the majority opinion so—its concern was with what seemed the Board’s willful refusal even to consider the admonition or the case law in determining bargaining units in the health-care industry.) The admonition lies between the polar cases of a committee report that does not accompany legislative action and a committee report that explains a newly enacted or amended statute, but is we think closer to the latter. It accompanied the enactment of substantial amendments. The particular statutory provision to which the admonition was addressed was not amended, but the effect of the amendments was to apply that provision for the first time to the nonproprietary hospital industry. Section 9(b) directs the Board to determine the “appropriate” unit, and what is appropriate may differ from one industry to another—may therefore “mean” something different in one industry from what it means in another. So in changing the domain of application of section 9(b), the 1974

amendments may have changed its meaning without changing its words. The admonition can therefore be regarded as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action—the case in *Pierce v. Underwood*, 108 S. Ct. 2541, 2551 (1988), and *Center for Auto Safety v. Peck*, 751 F.2d 1336, 1351 (D.C. Cir. 1985).

And yet the fact that the hospital industry would have dearly loved to amend the unit-determination provision yet failed to do so must give us pause in treating the “admonition” as if it were a statute, which anyway it plainly is not. To treat it as one would give the hospital industry something it tried and failed to win from Congress. Moreover the admonition does not *read* like a statute. It is cautionary rather than directive. It expresses a concern felt by many members of Congress, including those who were responsible for shepherding the bill through both houses, and such an expression is entitled to our respectful consideration, not only for its intrinsic merits but also for what light it sheds on Congress’s intentions in the 1974 amendments. But it is not an amendment to section 9(b), decreeing that in the health-care industry no more than three separate bargaining units shall be authorized.

It could not properly be so interpreted even if it were a statute, rather than a statement in committee reports. The background against which the committees expressed their concern with unit proliferation was one to which the word “proliferation” far more compellingly applied than it does to the eight units (three statutory) prescribed in the Board’s rule. There are many more than eight groups of hospital employees who consider themselves to have common interests distinct from those of the other groups. Congress was told that New York State’s counterpart to

the NLRB had recognized more than 21 separate bargaining units in the hospitals of New York. Hearings on H.R. 11357 Before the Subcomm. on Labor of the S. Comm. on Labor and Public Welfare, 92d Cong., 2d Sess. 300-01 (1972). *That* is proliferation; that is the sort of unit metastasis that “due consideration” could be expected to persuade the Board to disallow. The cases cited in the admonition were ones in which the Board had rejected minuscule or arbitrary units of specialized nonprofessional employees. The rejected unit in *Four Seasons Nursing Center*, 85 L.R.R.M. 1093 (1974), had only two members. In *Woodland Park Hospital*, 84 L.R.R.M. 1075 (1973), the rejected unit consisted of X-ray technicians, and the Board found that they were no different in material respects from the other technicians employed by the hospital. And in *Extendicare of West Virginia, Inc.*, 83 L.R.R.M. 1242 (1973), the Board rejected the employer’s request for a single bargaining unit, instead recognizing separate units of technical employees, service and maintenance employees, and licensed practical nurses. Even if we indulge the heroic assumption that members of Congress had actually read the cases, but see *Friedrich v. City of Chicago*, 888 F.2d 511, 517 (7th Cir. 1989), neither the cases cited in the admonition nor the admonition itself reads on the issue of the propriety of eight units. So it is merely a detail that the footnote to the admonition makes the committee’s view of *Extendicare* completely inscrutable.

At argument we pressed counsel for examples of cases in which, either before or after 1974, the Board or a court had deemed the failure to combine workers from two or more of the eight separate units recognized by the Board’s rule—say, clerical workers with maintenance workers, or licensed practical nurses with orderlies, or psychologists with physical therapists—a manifestation of proliferation. No examples were forthcoming. The term has always had

reference to finer divisions of the health-care work force than attempted in the rule under challenge.

The last ground on which the industry defends the injunction is that the Board's rule is arbitrary, because it lumps together hospitals of different sizes and missions in different locations. All acute-care hospitals are covered, from the smallest rural hospital having at least six employees in one or more of the prescribed units to the largest metropolitan hospital. This is an important criticism but it would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of a rule; the only alternative it proposed is a rule that would state a rebuttable presumption that the three statutorily separate units are appropriate. Such a rule is no rule. It simply assigns to the unions the burden of persuading the Board to allow more units than the statutory minimum. There is no basis for placing this burden on the unions, especially given the statutory declaration that unit determination is to be guided by the desirability of maximizing the bargaining freedom of the employees.

Another way in which the industry failed to respond constructively to the Board's desire to bring unit determination in the acute-care hospital industry under a rule was by failing to press for an increase in the six-employee minimum. If the minimum were, say, fifteen, the effect would be to confine the rule to the larger hospitals. But the industry did not ask the Board to fix a higher minimum. Quite the contrary, it joined the unions in opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer. 53 Fed. Reg. at 33927.

The lumping together of all acute-care hospitals into one category for purposes of prescribing proper bargaining

units does of course overlook a great deal of relevant diversity. What the hospital industry refuses to acknowledge is that this is the very nature of rules. A rule makes one or a few of a mass of particulars legally decisive, ignoring the rest. The result is a gain in certainty, predictability, celerity, and economy, and a loss in individualized justice. Often the tradeoff is worthwhile; at least the prevalence of rules in our legal system so suggests. The hospital industry is acutely conscious of the costs of rules, but disregards the benefits. Because of the absence of statutory guidance and the complexity and uncertainty of the balance that the Board is required to strike in order to determine an appropriate unit, unit determination when made on a case by case basis has all the disadvantages of discretionary justice.

For its first forty-four years the Board tried to channel its discretion over unit determination in common law fashion, proposing and modifying standards case by case. That was the approach it took when the nonprofit health care sector was brought under its aegis in 1974. The approach is widely regarded as a failure, not least by the courts of appeals, including this court; certainly the Board was entitled to regard it as such. "Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974." 52 Fed. Reg. at 25143. Against this dismal background it was not unreasonable for the Board to experiment with substituting a tight rule for a loose standard. Necessarily the result would be a suppression of relevant detail. Although the rule is not as simple as it could be—it does not cover the entire health-care industry but only acute-care hospitals, and it leaves an open-ended

exception for cases in which a party can demonstrate exceptional circumstances—it could of course be less simple. It could differentiate among acute-care hospitals by size, location, or mission (e.g., primary versus secondary versus tertiary care hospitals). The Board considered these possibilities but decided against them. It gave plausible reasons for its choice.

The decision how complex to make a rule—that is, how many exceptions to recognize—is judgmental, like the decision whether to make rules by formal rulemaking or by the common law method of case-by-case adjudication. *NLRB v. Bell Aerospace Co.*, *supra*, 416 U.S. at 290-95. The decision how much discretion to eliminate from the decisional process is itself a discretionary judgment, entitled to broad judicial deference. *Heckler v. Campbell*, *supra*, 461 U.S. at 467-68; *Fook Hong Mak v. INS*, 435 F.2d 728, 730 (2d Cir. 1970) (Friendly, J.); *Midtec Paper Corp. v. United States*, 857 F.2d 1487, 1501 (D.C. Cir. 1988). It is not for us to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions than it does, or slightly fewer. The Board did a responsible job of weighing the conflicting arguments, and we therefore uphold its rule without pretending that we consider it Utopia. And there was no statutory obstacle to the Board's bringing the unit-determination process in the hospital industry under the aegis of a rule.

The injunction is vacated with directions to enter judgment for the Board.

REVERSED

No. 89 C 3279

IN THE
UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

July 25, 1989

AMERICAN HOSPITAL ASSOCIATION,
Plaintiff,
v.

NATIONAL LABOR RELATIONS BOARD, James M.
Stephens, Mary M. Cracraft, John E. Higgins, Jr.,
Dennis M. Devaney, and John C. Truesdale,
Defendants,
and

American Federation of Labor and Congress of Industrial
Organizations, the Building and Construction Trades
Department, and American Nurses' Association,
Permissive Intervenors Pursuant to Fed.R.Civ.P. 24(b)

MEMORANDUM OPINION AND ORDER

ZAGEL, *District Judge*.

The American Hospital Association (the "AHA") seeks to permanently enjoin the National Labor Relations Board (the "NLRB" or the "Board") from enforcing a newly promulgated rule, 29 C.F.R. Part 103, pertaining to bargaining units in the health care industry (the "Rule").¹ The Rule was promulgated pursuant to the Board's rule-

¹ On April 21, 1989, AHA filed a complaint in this court seeking an injunction enjoining enforcement of the Board's Rule and a judgment that the Rule is invalid. On May 22, 1989, this court issued a preliminary injunction and ordered an expedited briefing schedule.

making authority under section 6 of the National Labor Relations Act (the “NLRA” or the “Act”), 29 U.S.C. sec. 156 (1988), and the procedures set forth in section 553 of the Administrative Procedures Act (the “APA”), 5 U.S.C. sec. 553 (1988). If given effect, the Rule will establish eight units for the purposes of collective bargaining in acute care hospitals. Prior to this Rule the Board’s policy was to determine the appropriateness of bargaining units in individual cases. The AHA asks us to declare this Rule invalid on three alternative grounds: 1) the Rule contravenes section 9(b) of the Act, 29 U.S.C. sec. 159(b) (1988), which provides that bargaining unit determinations must be made “in each case”, 2) the Rule contravenes the 1974 Health Care Amendments which mandate that the Board avoid undue proliferation of bargaining units in the health care industry and 3) the Rule is arbitrary and capricious and is not supported by substantial evidence. The NLRB has filed a motion for summary judgment.²

I. BACKGROUND

A. Legislative Enactments

The Wagner Act (National Labor Relations Act of 1935, 29 U.S.C. secs. 151, *et seq.* (1935)), was enacted to pro-

² The Board asked this court to dismiss the AHA’s complaint for lack of jurisdiction. The Board argued that the district court has no jurisdiction over a representation decision; section 9(d), 29 U.S.C. sec. 159(d), provides a specific mechanism for such review and any judicial review must take place in the court of appeals. We denied the Board’s request for dismissal (oral ruling, May 19, 1989) because plaintiff does not ask us to determine the validity of representation under the new Rule, but questions the Board’s authority to promulgate the rule. We are not foreclosed from review of the Board’s rule-making authority. *American Medical Ass’n v. Weinberger*, 395 F.Supp. 515 (N.D. Ill.), *aff’d*, 522 F.2d 921 (7th Cir. 1975).

mote unionization and collective bargaining. After a time, Congress found that the Wagner Act unduly favored unions over companies and Congress passed the Taft-Hartley Act, amending the Wagner Act and creating a more balanced statutory scheme, while continuing the right of employees to be free from employer coercion. See C. Morris, *The Developing Labor Law* 437 (2d ed. 1983).

In 1974 Congress amended the Act to cover all private health care institutions, including not-for-profit hospitals.³ Act of July 26, 1974, Pub.L. No. 93-360, 88 Stat. 395 (hereinafter “Health Care Amendments”). At this time Congress also recognized that labor regulation in the health care industry involves distinctive considerations. Patient treatment cannot tolerate interruption because health institutions provide care to the sick, the aged and the infirm. A disturbance in health care services is more serious than a break, for example, in industrial plant production. See *St. Vincent Hospital v. NLRB*, 567 F.2d 588, 590 (3rd Cir. 1977).

Ironically, the health care industry is particularly vulnerable to labor unrest. The industry is highly specialized and consists of many—frequently unrelated—professional and vocational specialties. Although only a few employees in each specialty may concentrate in a particular hospital, there is the potential for numerous job classifications and consequently the danger that collective bargaining units will proliferate. The greater the number of units, the

³ Under the Wagner Act all hospitals were subject to federal regulation. The Taft-Hartley Act, however, exempted not-for-profit hospitals. In 1960, the Board included for-profit hospitals within the regulatory exemption, reasoning that hospitals were essentially local operations which did not operate in interstate commerce. *Flatbush General Hospital*, 126 NLRB 144 (1960). The Board reversed this exemption in 1967. *Butte Medical Properties*, 168 NLRB 266 (1967).

stronger the likelihood of labor unrest, which in turn jeopardizes the functioning of health care facilities. This is because the more units there are in a particular hospital, the fewer employees that have to agree to call a strike. See *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1469 (7th Cir. 1983). Although it may be true that the smaller the unit the less critical an impact the strike will have, this may not be true in a health care institution where frequently each group of employees plays a significant role in the patient care and where the service cannot be prepared in advance. *Id.* Thus, the pattern of bargaining units organized in health care facilities has a considerable impact on the institutions.⁴

In order to protect the health care industry Congress included in the Health Care Amendments special provisions that lengthen the strike notice period and require federal mediation. NLRA sec. 8(d)(A)-(C), (g), 29 U.S.C. sec. 158(d)(A)-(C), (g). Congress, however, neither amended section 9 of the Act, 29 U.S.C. sec. 159, the provision which controls determination of bargaining units by the Board, to reflect their concern over proliferation of bargaining units, nor accepted a proposal by Senator Taft

⁴ One commentator notes with respect to the vulnerability of health care institutions to labor unrest:

The numbers and types of units established can reasonably be expected to have an impact upon the incidence of labor disputes in health care institutions, and thus, upon the interruption of the delivery of services by such institutions, the costs of health care services, the administrative burden of managing health care institutions, the effectiveness of the organizational efforts of labor organizations and of their representation of employees, and the effectiveness of the collective bargaining process.

Bumpass, *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L.Rev. 867, 868 n. 8 (1979).

which would have limited, by statute, the number of bargaining units to five (including guards) in non-profit health care institutions. S. 2292, 93 Cong., 1st Sess. (1973), reprinted in, *Legislative History of the Coverage of Non-profit Hospitals Under the National Labor Relations Act* at 457-58 (hereinafter "*Legis. Hist.*"). Instead, Congress, in both the House and Senate Committee Reports, expressed its concern by admonishing the Board to give due consideration "to preventing proliferation of bargaining units in the health care industry." Congress' statement was, in its entirety:

EFFECT ON EXISTING LAW

Bargaining Units

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1975 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).¹

¹ By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

Legis. Hist., at 12, 274-275.

B. Bargaining Unit Determinations

Section 7 of the Act, 29 U.S.C. sec. 157 (1988), gives employees the right of self-organization. In the absence of an agreement between the employer and the employees, a union can obtain recognition for the purposes of collective bargaining by petitioning the Board under section 9

of the Act, and the Board must determine if employees in the petitioned-for unit form an appropriate bargaining unit.⁵ Section 9(b) instructs the Board that an appropriate unit is one which will "assure to employees the fullest freedom in exercising the rights guaranteed by . . . [the] Act." The Act prevents the Board from using the "extent to which the employees have organized" as controlling in certifying election petitions. NLRA sec. 9(c)(5), 29 U.S.C. sec. 159(c)(5). The Act provides the Board with little other guidance in charging it to determine appropriate bargaining units for certification, thus the Board possesses broad discretion in this area. *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72, 92 S.Ct. 383, 393-94, 30 L.Ed.2d 341 (1971); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 214 (7th Cir. 1978). Where, as here, a statute entrusts an agency with broad discretion to make decisions, a court will usually review the agency action under the deferential "abuse of discretion" standard. *NLRB v. Res-Care*, 705 F.2d 1461. Indeed, this is the standard generally used in unit determination cases. *Id.*

Unit determination requires that the Board weigh the competing interests of the employer and the employees. Employers seek few units with a greater number of workers presumably because many small units increase the likelihood of strikes and require repetitious bargaining, resulting in increased costs. If the units are too large, however, it impinges on the employees' right to union representation because too diversified a constituency may generate conflicts of interest and dissatisfaction within the

⁵ Specifically, under NLRA sec. 9(b), 29 U.S.C. sec. 159(b) (1988), the Board must determine whether an "employer unit, craft unit, plant unit or subdivision thereof * * *" constitutes an appropriate bargaining unit.

group. *Id.* Generally, the Board's unit determinations are based on a "community of interest" standard.⁶ C. Morris, *supra*, at 416-17. Under this principle employees with similar interests appropriately would be placed together for the purposes of collective bargaining. See, e.g., *In re Chrysler Corp.*, 1 NLRB 164, 169-70 (1936). Given the broad discretion permitted the Board, it would seem difficult for the courts to find fault with the community-of-interest standard. *Res-Care*, 705 F.2d at 1469. Nonetheless, in the fifteen years since the Health Care Amendments were enacted reviewing courts have tended to be less deferential to the NLRB's authority to make unit determinations when health care employees are at issue. E.g., *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980) (because of Congressional admonition "Board must not rely exclusively on traditional community-of-interest analysis"). The court of appeals attributes their frequent rejection of the Board's orders to the Board's failure to properly consider Congress' admonition to avoid undue proliferation of bargaining units. See, e.g., *NLRB v. HMO Int'l/California Medical Group Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *Beth Israel Hosp. & Geriatric Center v. NLRB*, 677 F.2d 1343, 1345 (10th Cir. 1981); *cert. denied*, 459 U.S. 1025, 103 S.Ct. 433, 74 L.Ed.2d 522 (1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 455 (10th Cir. 1981), *cert. denied*, 459 U.S. 1025, 103 S.Ct. 433, 74 L.Ed.2d 522 (1982); *NLRB v. Mercy Hosp. Ass'n*, 606 F.2d 22 (2nd Cir. 1979), *cert. denied*, 445 U.S. 971, 100 S.Ct. 1665, 64

⁶ Under the "community-of-interest" standard an appropriate bargaining unit is identified by the following characteristics: similarity of wages and hours, extent of common supervision, frequency of contact with other employees, and area practice and patterns of bargaining. *Allegheny General Hospital*, 239 NLRB 872, 873 (1978), *enf. denied on other grounds*, 608 F.2d 965 (3rd Cir. 1979).

L.Ed.2d 248 (1980); *NLRB v. St. Francis Hosp.*, 601 F.2d 404 (9th Cir. 1979); *NLRB v. West Suburban Hosp.*, 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hosp. v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

In response to judicial criticism, in 1982 the Board introduced a new two-tiered approach for bargaining unit determination on health care, *St. Francis Hospital*, 265 NLRB 1025 (1982) (hereinafter "*St. Francis I*"). First, the Board would determine if the petitioned-for unit was one of the seven units identified as "potentially appropriate" (physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees). Second, the Board determined whether a community of interest existed among the employees in the unit and if it did the unit would be approved. A unit which did not coincide with any of the seven categories would be approved only in extraordinary circumstances. *Id.* at 1029.

When the hospital refused to bargain with the prevailing union in the unit approved in *St. Francis I*, the Board re-evaluated its two-tier approach in light of the judicial criticism of the community-of-interest approach. *St. Francis Hospital*, 271 NLRB 948 (1984) (hereinafter "*St. Francis II*"). The NLRB adopted a "disparity-of-interest" test which, the Board asserted, took better account of the Congressional Admonition against undue proliferation.⁷ The Board expressly indicated that it adopted this approach because it avoided a rigid standard which

⁷ A unit will be approved under the disparity-of-interest test if there exists "sharper than usual differences (or disparities) between wages, hours, and working conditions, etc., of the requested employees and those in an overall professional or nonprofessional unit." *St. Francis II*, 271 NLRB at 953.

would be inappropriate for the "diverse nature of today's health care industry", *id.* at 953 n. 39, and thus would comport "with Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis." *Id.* at 951 n. 17.

The Court of Appeals for the District of Columbia reversed *St. Francis II*, holding that while the disparity-of-interest standard was permissible under the Act, it was not a required interpretation and remanded the case to the Board for further explanation. *IBEW, Local Union 474 v. NLRB*, 814 F.2d 697, 708 (D.C. Cir. 1987). The NLRB accepted remand, but rather than seeking further review or explicating its disparity-of-interest approach, the Board announced its intent to invoke its section 6 rule-making authority and finally resolve the issue of appropriate bargaining units in the health care industry. *St. Francis Hospital*, 286 NLRB No. 123 (1987). *See also St. Vincent Hospital*, 285 NLRB No. 64 (1987). This litigation is the result of the Board's decision to determine unit appropriateness by rule-making.

C. The Rule-Making

On July 2, 1987, the Board published a Notice of Proposed Rulemaking and Hearing, explaining that it intended "to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities." Notice of Proposed Rulemaking, July 2, 1977, 52 Fed.Reg. 25142-49 (hereinafter "NPR I"). The Board indicated that it was abandoning its unsuccessful doctrinal approaches and would gather empirical evidence in order to make "an informed judgment as to what types of units should be found appropriate in the health care industry." NPR I, 52 Fed.Reg. 25144. In NPR I the Board proposed that

in large acute care hospitals with more than 100 beds six units (registered nurses, physicians, technical employees, service and maintenance and clerical employees except guards, and guards) would be appropriate. *Id.* at 25149.⁸ Following the publication of NPR I the Board gathered testimony and comments on the proposed rules.

On September 1, 1988, the Board published a Second Notice of Proposed Rulemaking (NPR II), 52 Fed.Reg. 33900-33935. In NPR II the Board abandoned the large-small hospital distinction and removed nursing homes and psychiatric hospitals from the scope of the proposed rule. NPR II, Fed.Reg. 33927-30. The Board also divided the service maintenance and clerical unit into three separate units consisting of skilled maintenance workers, business office clericals and service and other non-professional employees. *Id.* at 33920-27.

On April 21, 1989, the Board published the Final Rule. 29 C.F.R. Part 103, 54 Fed.Reg. 16336-48 (the "Rule"). Under the Rule the eight bargaining units proposed in NPR II would be the only units appropriate for collective bargaining in an acute care hospital, absent extraordinary circumstances. The Rule provides for a substantial departure from the method the Board used to make unit determinations over the last fifty years. The Board indicated that it deliberately chose to make the eight units determinative of appropriateness and not presumptively appropriate "because one important advantage of rule-making is the certainty it offers." NPR I, 52 Fed.Reg. 25145. The Board added that rules are more effective than rebuttable presumptions to resolve their concern with

⁸ In nursing homes and smaller hospitals the number of appropriate units would be limited to four. These were: all professional employees, all technical employees, all service, maintenance and clerical employees except guards, and all guards.

duplicative litigation. Final Rule, 54 Fed.Reg. 6338-39. The Board justifies its action by stating that in its experience "facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical." NPR I, Fed.Reg. 25145.

Although the Board leaves an opportunity for a hospital to remove itself from the general applicability of the rules by claiming an "extraordinary circumstance"⁹, the Board has signaled its intent to construe this exception narrowly "so that it would not provide an excuse, opportunity or 'loophole' for redundant and unnecessary litigation. . . ." NPR II, 52 Fed.Reg. 33923. Consequently, the Board enumerates several broad categories of concerns a hospital might advance to remove itself from the general applicability of the Rule which will not be considered. These issues, according to the Board, were addressed during the rule-making process, found not to affect a unit determination, and therefore, would not qualify for litigation under the extraordinary circumstance exception.¹⁰ In any event,

⁹ The Rule enables a facility claiming an extraordinary circumstance to present an offer of proof to a hearing officer who will either permit the evidence to be adduced or refer the offer to the Regional Director, or if requested, the Board. If it is determined that an extraordinary circumstance does not exist, the hospital can seek judicial review.

The Board does note that an extraordinary circumstance which will remove a unit from automatic coverage by the Rule is a petition for a unit comprised of five or fewer employees. Final Rule, 54 Fed.Reg. 16346.

¹⁰ According to the Board the following issues have already been considered and will not be subject to further litigation with respect to unit determinations:

. . . arguments relating to (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of out-patient services provided, and differing staffing patterns among facil-

(Footnote continued on following page)

the Board concludes that the rule reflects a natural and realistic grouping found in the health care industry and once the rule is in effect "no other unit will be found appropriate by the Board absent extraordinary circumstances."¹¹

The AHA believes these rules are invalid and sues for injunctive relief. The NLRB defends its new Rule and seeks summary judgment in its favor.

II. ANALYSIS

The AHA's complaint questions the scope of the Board's rulemaking authority under section 6 of the NLRA, in

¹⁰ *continued*

ities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multicompetent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above, alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

NPR II, 53 Fed.Reg. 33932 (footnote omitted).

¹¹ Board member Wilford W. Johansen dissented from the Board's decision to establish bargaining units through its rulemaking procedure. He stated that rule-making was foreclosed by section 9(b) and furthermore, in this context is "at best inadvisable." Final Rule, 54 Fed.Reg. 16347.

light of section 9(b), and in the particular context of the health care industry. Section 9(b) provides:

The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit or subdivision. . . . (Emphasis added.)

The AHA contends that the "in each case" language mandates that the Board make an individualized determination of appropriate bargaining units based on the particular facts of each case presented to the Board. The AHA says that the NLRB's new Rule pre-determines appropriate bargaining units, and thus, obviates the case-by-case review called for by 9(b). The Board, with its best argument, concedes that perhaps 9(b) contemplates that the Board will make a unit determination in each case in which a petition for a representation election is filed. Even so, the Board argues, 9(b) does not preclude the Board from promulgating general rules and regulations applicable to unit determination, pursuant to their section 6 power.

Congress afforded the Board broad discretion under section 9 of the Act to determine appropriate employee units for the purposes of collective bargaining. *IBEW, Local No. 474*, 814 F.2d at 699. We will not, however, sustain a use of this discretion if it is based on the Board's erroneous understanding of the statute. *Id.* (quoting *Prill v. NLRB*, 755 F.2d 941, 947 (D.C.Cir.), *cert. denied*, 474 U.S. 948, 106 S.Ct. 313, 88 L.Ed.2d 294 (1985). *Accord Ford Motor Co. v. NLRB*, 441 U.S. 488, 99 S.Ct. 1842, 60 L.Ed.2d 420 (1979).

A. Judicial Review

The starting point for any judicial interpretation of a statute must be the language of the statute itself and if

“we find the terms of a statute unambiguous, judicial inquiry is complete.” *In re Sinclair*, 870 F.2d 1340, 1341 (7th Cir. 1989) (quoting *Rubin v. United States*, 449 U.S. 424, 430, 101 S.Ct. 698, 701, 66 L.Ed.2d 633 (1981)). See also *Lewis v. United States*, 445 U.S. 55, 60, 100 S.Ct. 915, 918, 63 L.Ed.2d 198 (1980). This dispute rests on the meaning of the words “in each case.” These words are not necessarily inconsistent with the Board’s attempt to promulgate industry-wide rules, unless there is some indication that Congress required fact specific determinations in each case. We cannot rely simply on the plain meaning of 9(b) to determine the limitations the statute imposes on the Board’s section 6 rule-making authority. When the words of a statute are vague, so that a resolution cannot be gleaned from the words of the text, we must determine which interpretation “would best advance the legislative purpose.” *Virtual Network Services v. United States*, 98 B.R. 343, 345 (N.D.Ill. 1989) (quoting *Mechmet v. Four Seasons Hotels, Ltd.*, 825 F.2d 1173, 1175 (7th Cir. 1987)).

The NLRB suggests that because the text of the statute offers no determinative guidance, we are obligated to give deference to an agency interpretation which is based on a permissible construction of the statute. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2781-82, 81 L.Ed.2d 694 (1984). Accord *NLRB v. United Foods & Commercial Workers Union*, 484 U.S. 112, 108 S.Ct. 413, 421, 98 L.Ed.2d 429 (1987). But deference is due the agency only if its interpretation is rational and consistent with the statute. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 501, 98 S.Ct. 2463, 2473, 57 L.Ed.2d 370 (1978). Accord *Public Employees Retirement System of Ohio v. Betts*, — U.S. —, —, 109 S.Ct. 2854, 2863, 106 L.Ed.2d 134 (1989) (no deference due agency interpretation at odds with the

language of the statute itself); *SEC v. Chenery Corp.*, 332 U.S. 194, 196, 67 S.Ct. 1575, 1577, 91 L.Ed. 1995 (1947) (administrative order cannot be upheld unless the grounds upon which agency acted in exercising its powers were those upon which its action can be sustained). We refuse the Board’s invitation to defer to their interpretation of 9(b).¹² Although the language of the statute is not definitive, it does shed doubt on the extent of the Board’s authority.

It is not within our province to determine whether the AHA’s or the NLRB’s interpretation of 9(b) is best suited for the health industry. The political branches engage in a deliberate process to arrive at text which becomes law. *In Re Sinclair*, 870 F.2d at 1344. We must abide by their pronouncements. Legislative history, although it is not “a source of legal rules competing with those found in the U.S. Code . . .” may help “us learn what Congress meant by what it said.” *Id.* So, because the words of the statute do not lend a definitive answer with respect to the scope of the NLRB’s rule-making authority under 9(b) and because the NLRB’s Rule may in fact be inconsistent with the “in each case” language, we must examine Congress’ purpose.

¹² Consideration must also be given to the consistency with which the NLRB has interpreted a statute. Prior to the Rule, for over fifty years, the Board’s policy was to make bargaining unit determinations through administrative review of each petition, because, as the Board noted in *St. Francis Hospital*, 271 NLRB 948, 951 n. 17 (1984), Congress intended that it “exercise flexibility in dealing with the unit determinations on a case-by-case basis.” When, as here, an administrative agency vacillates in its interpretation of an authorizing statute, its interpretation is entitled to little deference. *NLRB v. United Food and Commercial Workers Union*, 484 U.S. 112, 108 S.Ct. at 421 n. 20; *County of Washington v. Gunther*, 452 U.S. 161, 177-78, 101 S.Ct. 2242, 2251-52, 68 L.Ed. 2d 751 (1981).

B. Rule-Making Authority Under Section 9(b)

The AHA and the Board agree that it is indicative of Congressional intent that the original texts of the Senate and House Bills did not contain the “in each case” language. See Senate Bill 1958, 74th Cong., 1st Sess., reprinted in, *I Legislative History of the National Labor Relations Act 1935*, at 1300 (1949) (hereinafter “*1935 Legis. Hist.*”, at ____); House Bill H.R. 6187 and 6288, 74th Cong., 1st Sess., reprinted in, *II 1935 Legis. Hist.*, at 2449, 2464. Later, House Bill H.R. 7978 was introduced which included the “in each case” language, and the Senate Bill was amended to conform to the H.R. 7978. The amendment was accepted by the House-Senate Committee. See *II 1935 Legis. Hist.*, at 3253-54. The parties do not agree, however, on the implications of Congress’ addition. The AHA says the language clearly signals Congress’ intent that bargaining unit determinations should be made by the Board on a case-by-case basis. As support the AHA cites to the House Labor Committee Report on H.R. 7978 which explains:

Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit, employer unit or other unit. *This matter is obviously one for determination in each individual case*, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination.

H.R.Rep. No. 969, 74th Cong., 1st Sess. (1935), reprinted in *II 1935 Legis. Hist.*, at 2930 (emphasis added).

The Board contends that the amendment was just a house-cleaning detail and refers to Labor Secretary Perkins’ comment that “in each case” was only one of several small amendments “made for the sake of clarity.”

I 1935 Legis. Hist., at 1442. According to the Board the statement in the Committee Report, cited by plaintiff, followed a discussion of which entity should make unit appropriateness decisions—the employer, the union or the government agency—and that therefore, the only significance of the words “in each case” is that unit determination will be the function of the Board.

We must adopt the AHA’s view of the Congressional intent for several reasons. First, the Board has failed to show that even if the amendment was small and only for the sake of clarity it is inconsistent with Congressional intent that unit determinations should be on an individual basis. In any event, Secretary Perkins’ understanding of the amendment carries little weight, no significance is to be accorded statements made by nonmembers in a Congressional hearing. See *Kelly v. Robinson*, 479 U.S. 36, 107 S.Ct. 353, 361-62 n. 13, 93 L.Ed.2d 216 (1986). On the other hand, the explanation in the House Report, a persuasive indicia of Congressional intent, provides compelling support that Congress contemplated that unit determinations would require fact specific inquiries. See *Mills v. United States*, 713 F.2d 1249, 1252 (7th Cir. 1983), cert. denied, 464 U.S. 1069, 104 S.Ct. 974, 79 L.Ed.2d 212 (1984) (generally, the committee report is “the most persuasive indicia of Congressional intent (with the exception, of course, of the language of the statute itself”).

The Board’s explanation that the House Report simply emphasizes that the Board is to make the unit determination is less plausible, we do not see how the words “in each case” serve to reiterate the Board’s authority. If we were to accept the Board’s construction, the words “in each case” become superfluous in the context of section 9(b), merely repeating Congress’ charge to the Board in the preceding phrase. We hesitate to condone such a result. *Zimmerman v. North American Signal Co.*, 704

F.2d 347, 353 (7th Cir. 1983) ("[a]s a general rule, a court should not construe a statute in a way that makes words or phrases meaningless, redundant, or superfluous.").

Finally, an important and obvious rule of statutory construction is that a particular statutory phrase should not be construed in isolation but with reference to the statute as a whole. *United States v. Morton*, 467 U.S. 822, 828, 104 S.Ct. 2769, 2773, 81 L.Ed.2d 680 (1984). One purpose of the NLRA is to provide employees with the right to bargain collectively, section 9(b) states specifically that the Board's unit determination must "assure to employees the fullest freedom in exercising the rights guaranteed." It is fair to say that an individualized determination of bargaining units appropriate in a particular institution or facility will better assure employees the "fullest freedom in exercising . . . [their] rights." Although the language "in each case" may not plainly indicate Congress' purpose, the fairer and more plausible interpretation is that Congress believed that for collective bargaining to fulfill the purpose for which it was meant, unit appropriateness should be considered by the Board on a case-by-case basis.

The AHA tells us that if we find that 9(b) contemplates individualized bargaining unit determinations, we must find the Board's Rule invalid. We disagree. The AHA still falls short of victory. The fact that the NLRB is statutorily bound to make determinations which are tailored to individual cases is not necessarily inconsistent with the Board's use of its section 6 rule-making authority. It would be a misuse of resources to prevent the Board from using fact gathering apparatus to develop principles applicable to recurring scenarios. It defies common sense to believe Congress would entrust unit determination to the Board under section 9 because of its experience and expertise, and then, simultaneously require it to face each

contested case *ab initio*. Indeed, there are persuasive arguments to encourage the Board to take advantage of its rule-making authority.¹³ Peck, *The Atrophied Rule-Making Powers of the National Labor Relations Board*, 70 Yale L.J. 729 (1961). Of course, there are equally compelling arguments that case-by-case adjudication is more appropriate to the Board's function. Although it may be cumbersome, case-by-case review is more amenable to the unique circumstances of employers and employees in diverse settings, and perhaps, a necessary burden for a labor policy which will extend to employees the fullest freedom to exercise their rights.

For our purposes in this litigation, however, it is sufficient to conclude that the Board is not foreclosed from rule-making in fulfilling its 9(b) charge. A definitive decision concerning the limitations on the Board's general rule-making authority with respect to bargaining unit ap-

¹³ One inherent advantage of using substantive rules is the consistency they provide. If the Board articulates clear labor policy through rule-making then the people will know what the law requires and the extent of their rights. Rule-making advances policy which can be applied uniformly by Board representatives, whereas case-by-case adjudication, even when rules derived by adjudication are applied, emphasizes only the facts before the Board, thus giving rise to haphazard policy and disparate treatment of parties. Bernstein, *The NLRB's Adjudication-Rule Making Dilemma Under the Administrative Procedure Act*, 79 Yale L.J. 571, 590-91 (1970) ("[r]ulemaking provides the agency with the opportunity to initiate changes in its own doctrine whereas adjudication leaves the initiative to the few private parties who have the resources, the hardheadedness, or the the innocence to persevere in the litigation process"). The Board's ability to act on particular matters is limited to the controversies brought to its attention, only its rule-making authority and the procedures outlined in the APA enable the Board to gather diverse and informed opinions and gain a broader overview of the reality of the workplace. See Morris, *The NLRB in the Dog House—Can an Old Board Learn New Tricks?*, 24 San Diego L.Rev. 9 (1987).

propriateness can be left for another day. This case presents a far narrower issue: the extent of the Board's rule-making authority under 9(b) in the context of the health care industry. This changes the nature of the inquiry. Both the legislative and judicial branches have recognized health care as a unique and complex industry, and as discussed above, generally applicable standards frequently have been revised or even rejected when applied in the context of the health care field. See e.g., *Mary Thompson Hospital v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980).

C. Congress' Admonition Against Undue Proliferation

The stakes are higher when the Board makes bargaining unit determinations in the health care field; fragmentation of the workforce is more likely and of greater concern when patient care is at issue. Congress drew attention to the distinctive vulnerability of health care by enacting amendments to the NLRA in 1974 and, particularly, by stating in both the Senate and House committee reports that the Board should avoid undue proliferation of bargaining units in the health care industry. Much authority has been given to this admonition and many circuits have reversed the Board for failing to give proper credence to the Congress' expressed concern. Although a number of circuit court judges have questioned how much weight the committees' statement should be given, *Res-Care*, 705 F.2d at 1470 (Posner, J.); *IBEW, Local 747*, 814 F.2d at 712 (Edwards, J.), the Seventh Circuit, and others, have treated the statement as authoritative. See, e.g., *Res-Care*, 705 F.2d at 1470; *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

1.

The question of how much proliferation is undue has not been resolved in this circuit. *Res-Care*, 705 F.2d at 1470. An absolute answer to this question is not required to conclude that the Board's Rule will create undue proliferation. Suffice it to say, that it is evident that the Board has failed to give "more than mere lip service mention of the Congressional admonition", *NLRB v. West Suburban Hospital*, 570 F.2d at 216, when it promulgated its new Rule. The Rule mandates *automatic* fragmentation of the workforce into eight units, without regard to the nature and extent of the health services rendered or the dynamics of a particular health care institution.¹⁴

The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) and the Building and Construction Trades Department note that proliferation is but one factor that the Board must take into account when it makes unit determinations and while the rule may implicate the proliferation concern, other factors, such as section 9(b)'s directive to assure employees the fullest freedom in bargaining, must also be factored into the Board's decision. Congress only required the Board to give proliferation "due consideration" and it was not an abuse of discretion for the Board to establish the units

¹⁴ When Congress was in the process of making changes to the Act in 1974, Senator Taft proposed a bill that he intended would prevent proliferation by statutorily designating only five permissible bargaining units in the health care institutions. *1974 Legis. History*, at 106-12. The AHA argues that Congress' rejection of that Bill is conclusive evidence that Congress did not envision pre-determined units. We are not convinced, and this is not how we reach the decision that pre-determined units do not prevent proliferation. A plausible reading of Congress' refusal to statutorily determine bargaining units would also be that the House and Senate believed that the agency which Congress had authorized to make these decisions had more expertise to do so.

in the Rule if they accommodated other Congressional concerns. Although a compelling argument, this is not the way we understand the policy against proliferation.

There are general directives which the Board must follow whenever it makes a unit appropriateness decision in whatever the industry. But Congress drew attention to health care by adding another concern, which must be addressed by the Board in certifying bargaining units in that industry. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, it must use the means least likely to cause unit proliferation to achieve their objective. Although we can agree with the Board that the eight units they establish are appropriate and in many instances may match the natural divisions among the employees in health care institutions, we can envision other divisions, perhaps fewer divisions, in the varied health institutions which would be equally reasonable.

2.

In its defense the Board argues that the Rule is functionally no different than adjudicated rules of general applicability which the Board has relied on with judicial approval. *National Labor Relations Board v. Metropolitan Life Insurance Co.*, 380 U.S. 438, 443 n. 6, 85 S.Ct. 1061, 1064 n. 6, 13 L.Ed.2d 951 (1967) (affirming Board's authority to determine appropriateness of different bargaining units by decisions of general applicability). Adjudicated rules develop where a principle established in one case is applied to subsequent representation cases to determine appropriate bargaining units. See, e.g., *Big Y Foods v. NLRB*, 651 F.2d 40, 45 (1st Cir. 1981) (presumption that separate meat department is appropriate); *NLRB v. New Enterprise Stone & Lime Company*, 413 F.2d 117,

118 (3rd Cir. 1969) (separate warehouse unit appropriate where three conditions are met).

From the onset these cases are distinguished because not one of the cases cited by the Board involves unit determination in the health care industry. Thus, the express policy against proliferation has no bearing in these cases. In addition, rule-making by adjudication is fundamentally different than a rule promulgated under the APA procedures, because an adjudicated rule evolves only in context where parties have litigated their unique concerns and can only be applied in a similar context. An adjudicated rule may be adapted to factual distinctions, whereas the Board's rule which predetermines units, necessarily ignores differences which, although the Board refers to them as subtle, may be the key to labor peace.¹⁵

Similarly misplaced is the Board's reliance on *Heckler v. Campbell*, 461 U.S. 458, 103 S.Ct. 1952, 76 L.Ed.2d 66 (1983). In *Heckler* the Supreme Court upheld the Secretary's use of medical-vocational guidelines, developed by

¹⁵ We do not rely on *NLRB v. Wyman-Gordon*, 394 U.S. 759, 89 S.Ct. 1426, 22 L.Ed.2d 709 (1969), where the Court notes that adjudicated precedent "guides future conduct in much the same way as though it were a new rule promulgated under the rule-making power." *Id.* at 771, 89 S.Ct. at 1432 (Black, J., concurring). The Supreme Court does not, as defendant argues, endorse rule-making, but criticizes the Board for using adjudication where rule-making and the procedures of the APA are authorized. Furthermore the Supreme Court's comments are not in the context of unit determinations.

Nor do we rely on *NLRB v. Metropolitan Life Insurance Co.*, 380 U.S. 438, 443 n. 6, 85 S.Ct. 1061, 1064 n. 6, 13 L.Ed.2d 951 (1965) where the Court noted "the Board may articulate the basis of its [unit determination] order by reference to other decisions and to general policies laid down in its rules. . . ." This reference is *dicta*, however, and only endorses the view that in appropriate circumstances the Board will not be barred from using its section 6 rule-making authority.

rule-making, to determine a claimant's right to disability benefits, although the Social Security Act contemplates individualized hearings. *Heckler* is distinguishable. The individualized review of the claimant's case is not obviated by the Secretary's rules, because a hearing is required to determine the claimant's particular limitations and abilities before the Secretary can even use the guidelines. The determination of whether a job exists for a claimant once his or her particular qualifications are assessed, is no longer a question subject to factual distinctions, *Heckler*, 461 U.S. at 467, 103 S.Ct. at 1957, unlike the determination of unit appropriateness which depends on the dynamics of a specific health care institution. Finally, the Secretary does not claim any medical expertise and the guidelines replace the Secretary's reliance on a vocational expert. The Board's primary function and expertise, however, is supervising labor relations.

The AFL-CIO argues that preconceived determinations are inescapable, because as a practical matter the representation process could not function if the Board did not identify particular employee groups which constitute appropriate units. Employees must be aware of the Board's policy to exercise their right of self-organization and employers must also, to properly respond to representation claims. Thus, the AFL-CIO implies the Rule establishes, more expeditiously and less disingeniously [sic], what the NLRB must do anyway. We agree, for representation procedures to function certain principles must be presumed. But these principles are more analogous to guidelines or rebuttable presumptions than to rules. Rule-making is inherently less flexible which means that health care employees will be encouraged, or perhaps even coerced, by the Rule to organize according to the eight established units even in facilities where such fragmentation is un-

necessary.¹⁶ And, without a doubt, this result does not prevent undue proliferation.¹⁷

III. CONCLUSION

In sum, we find, that section 9(b) of the NLRA does not entirely foreclose the Board from promulgating rules with respect to appropriate collective bargaining units. Congress, however, enunciated a specific concern for the vulnerability of the health care industry to labor unrest. In light of this vulnerability Congress admonished the Board to give due consideration to undue proliferation of bargaining units in this industry. A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express con-

¹⁶ For the last fifteen years the Board has explored several alternatives to establish a coherent policy for unit determination in the health care industry. The Board has been frequently criticized by the judiciary and accused of pursuing an erratic course. The Board's attempt to establish concrete policy through their rule-making authority may be laudable. Yet the simple fact that the Board was unable to develop criteria for unit determination without raising judicial concern in particular cases, where one health care institution was at issue, should have been indicative of the difficulties of a rigid, generally applied policy in a field where the institutions are so diverse.

This is not to say that a combination of rule-making and adjudication could not be beneficial. Rule-making could provide guidelines which facilitate representation for all parties (unions, employers and employees) yet leave room for adjudication to consider the particular dynamics of a hospital or other health care facility.

¹⁷ Because we find that the Board's Rule is inconsistent with the policy against proliferation of bargaining units in the health care industry, we need not address AHA's argument that the new Rule is arbitrary and capricious.

cern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

A permanent injunction will issue where the plaintiff succeeds on the merits and if the balance of equities favors injunctive relief. For the reasons stated above the AHA has succeeded on the merits of its claim. The unique concerns in the health care industry favor injunctive relief. The appropriate remedy is to permanently enjoin the NLRB's Final Rule, 29 C.F.R. Part 103, establishing bargaining units in the health care industry, from taking effect.

The NLRB's Motion for Summary Judgment is denied and the petitions to intervene of the AFL-CIO, the Building and Construction Trades Department and the American Nurses' Association are granted.¹⁸

SO ORDERED.

¹⁸ The AFL-CIO, the Building and Construction Trades Department and the American Nurses' Association (the "ANA") sought to intervene as defendants. We found that they were not intervenors as of right (oral ruling, May 19, 1989). At that time we granted the AFL-CIO, the Building and Construction Trades Department and the ANA *amici* status and continued their Motion for Permissive Intervention. We now grant them status as permissive intervenors, pursuant to Fed.R.Civ.P. 24(b).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), provides:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof: *Provided*, That the Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit; or (2) decide that any craft unit is inappropriate for such purposes on the ground that a different unit has been established by a prior Board determination, unless a majority of the employees in the proposed craft unit vote against separate representation or (3) decide that any unit is appropriate for such purposes if it includes, together with other employees, any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises; but no labor organization shall be certified as the representative of employees in a bargaining unit of guards if such organization admits to membership, or is affiliated directly or indirectly with an organization which admits to membership, employees other than guards.

The National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-16348, 29 C.F.R. § 103.30, provides:

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of

this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. *Provided That* a unit of five or fewer employees shall constitute an extraordinary circumstance.

(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.

(c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to sec. 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after May 22, 1989.

(f) For purposes of this rule, the term:

(1) "Hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(e), as revised 1988);

(2) "Acute care hospital" is defined as: either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals. Where, after issuance of a subpoena, an employer does not produce records sufficient for the Board to determine the facts, the Board may presume the employer is an acute care hospital.

(3) "Psychiatric hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(f)). —

(4) The term "rehabilitation hospital" includes and is limited to all hospitals accredited as such by either Joint Committee on Accreditation of Healthcare Organizations or by Commission for Accreditation of Rehabilitation Facilities.

(5) A "non-conforming unit" is defined as a unit other than those described in paragraphs (a)(1) through

(8) of this section or a combination among those eight units.

(g) Appropriate units in all other health care facilities: The Board will determine appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended by adjudication.

(5)

No. 90-97

Supreme Court, U.S.

FILED

SEP 6 1990

JOSEPH F. SPANIOLO, JR.
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,
v.

NATIONAL LABOR RELATIONS BOARD, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

**RESPONSE OF RESPONDENT
AMERICAN NURSES ASSOCIATION**

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In view of the acquiescence of respondents National Labor Relations Board ("NLRB" or "the Board") and American Federation of Labor and Congress of Industrial Organizations to a grant of certiorari in this case, respondent American Nurses Association ("ANA") does not oppose the American Hospital Association's ("AHA") Petition.¹ We nonetheless consider it important to respond to three aspects of the Petition:

¹ Pursuant to Rule 29.1 of the Rules of this Court, ANA states that it has no parent or subsidiary companies (other than wholly-owned subsidiaries).

1. The dispositive question in this case (and indeed in litigation in this area generally since the 1974 enactment of the Health Care Amendments Act) is the legal effect, if any, of the nineteen-word statement which appeared in the congressional committee reports accompanying that Act: "Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry." It is our position, and that of the D.C. Circuit in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (1987) ("*St. Francis III*"), that this so-called congressional "admonition" has no legal significance. The *St. Francis III* court summarized its holding as follows:

We believe that in *St. Francis II* the Board failed to exercise its discretion under section 9 and instead rested its decision on a faulty legal premise. The Board ignored fundamental principles of statutory interpretation when it found that the 1974 Amendments to the Act *mandate* the disparity-of-interest standard. While the House and the Senate Committee Reports and statements by individual legislators express some concern over proliferation of bargaining units in health-care institutions, Congress, in the final analysis, decided against modifying section 9 of the Act. Although legislative history may give meaning to ambiguous statutory provisions, courts have no authority to *enforce* alleged principles gleaned *solely* from legislative history that has no statutory reference point. [814 F.2d at 699-700, emphasis in original, footnotes omitted.] ²

As the *St. Francis III* decision recognized:

[T]he Committee Reports' admonition against undue proliferation is *not* part of the Act. While a

² AHA thus rewrites history when it asserts (Pet. at i) that the courts of appeals have rejected Board health care unit determinations because they failed to give "proper weight" to the "congressional admonition against proliferation." As the above quotation from the *St. Francis III* decision makes plain, *St. Francis III* was a defeat for the NLRB precisely because the Board in that case had erroneously treated the admonition as though it had the force of law.

committee report may ordinarily be used to interpret unclear language contained in a statute, a committee report cannot serve as an *independent statutory source having the force of law*. * * * [*Id.* at 712, emphasis in opinion, footnote omitted.]

Judge Buckley's concurrence in *St. Francis III* succinctly states our position:

as the admonition and the remarks addressed to it were divorced from the legislation then before Congress, they are an illegitimate source of authority for the agency's construction of the law. See maj. op. at 713. [*Id.* at 717.]

The court below (Pet. at 10a) likewise agreed that Congress "does not legislate by issuing committee reports," and that "[t]he admonition in the 1974 committee reports is certainly not a statute." (Pet. at 11a). Rather, the admonition should be regarded "as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history"; to read the admonition as a statute "would give the hospital industry something it tried and failed to win from Congress." (Pet. at 12a).

2. Point II of the Petition is not properly before this Court. AHA there argues that the Board's rule impermissibly creates an irrebuttable presumption that the eight bargaining units fashioned by the rule are appropriate. But this is *not* the argument which AHA made in the court of appeals. AHA's "congressional admonition" argument in the court below instead was that the *number* of permissible units under the Board's rule (eight) was illegal. It was, of course, that position which was addressed and rejected in the court of appeals' opinion (Pet. at 8a-14a). In the Seventh Circuit, AHA did not oppose *presumptions as such*; indeed, as that court observed, the industry had before the Board proposed "a rule that would state a rebuttable presumption that the three statutorily separate units are appropri-

ate." (Pet. at 14a). AHA's change of theory in its Petition bespeaks an entirely justified lack of confidence in its position in the court of appeals, but AHA nowhere explains why this Court should deviate from its traditional rule and reach the merits of an issue not raised in the court below. See, e.g., *City of Canton v. Harris*, — U.S. —, 109 S.Ct. 1197, 1203, n. 5 (1989); *FTC v. Grolier, Inc.*, 462 U.S. 19, 23, n. 6 (1983); *Rogers v. Lodge*, 458 U.S. 613, 628, n. 10 (1982); *Adickes v. Kress & Co.*, 398 U.S. 144, 147, n. 2 (1970), and cases cited *id.*

3. As to Point III of the Petition, we note that, merits aside, this Court may conclude upon plenary consideration of the record that "there is no justification for this Court's intervention" (*Golden State Bottling Co. v. NLRB*, 414 U.S. 168, 174 [1973]), because this issue is fact-specific and does not involve "principles the settlement of which is of importance to the public as distinguished from that of the parties." *Labor Board v. Pittsburgh S.S. Co.*, 340 U.S. 498, 502 (1951).

CONCLUSION

If the Petition is granted, the decision of the court of appeals should be affirmed in its entirety.

Respectfully submitted,

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SEP 6 1990

JOSEPH F. SPANIOLO, JR.
CLERK

No. 90-97

In the Supreme Court of the United States**OCTOBER TERM, 1990****AMERICAN HOSPITAL ASSOCIATION, PETITIONER****v.****NATIONAL LABOR RELATIONS BOARD, ET AL.****ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT****BRIEF FOR THE NATIONAL LABOR RELATIONS BOARD.****KENNETH W. STARR***Solicitor General***DAVID L. SHAPIRO***Deputy Solicitor General***STEPHEN L. NIGHTINGALE***Assistant to the Solicitor General**Department of Justice**Washington, D.C. 20530**(202) 514-2217***JERRY M. HUNTER***General Counsel***D. RANDALL FRYE***Acting Deputy General Counsel***ROBERT E. ALLEN***Associate General Counsel***NORTON J. COMB***Deputy Associate General Counsel***LINDA SHER***Assistant General Counsel**National Labor Relations Board**Washington, D.C. 20507*

QUESTIONS PRESENTED

The National Labor Relations Board promulgated a regulation specifying the eight bargaining units that, in the absence of extraordinary circumstances, will be recognized as appropriate for all acute care hospitals. The questions presented are:

1. Whether the regulation violates the provision of Section 9(b) of the National Labor Relations Act, 29 U.S.C. 159(b), that the "Board shall decide [the appropriate bargaining unit] in each case."

2. Whether the regulation is consistent with 1974 amendments to the National Labor Relations Act that extended the Act to nonprofit health care institutions and with statements in the amendments' legislative history admonishing the Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry."

3. Whether the regulation is arbitrary and capricious in mandating the same bargaining units for all acute care hospitals absent a showing of extraordinary circumstances.

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In the Supreme Court of the United States

OCTOBER TERM, 1990

No. 90-97

AMERICAN HOSPITAL ASSOCIATION

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS FOR
THE SEVENTH CIRCUIT

BRIEF FOR THE NATIONAL LABOR RELATIONS BOARD

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-16a) is reported at 899 F.2d 651. The opinion of the district court (Pet. App. 17a-42a) is reported at 718 F. Supp. 704.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1990. The petition for a writ of certiorari was filed on July 10, 1990. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

In addition to the provisions set forth at Pet. App. 43a-46a, Section 6 of the National Labor Relations Act, 29 U.S.C. 156, is pertinent. It provides:

The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by subchapter II of chapter 5 of title 5, such

(1)

rules and regulations as may be necessary to carry out the provisions of this Act.

STATEMENT

1. In 1974, Congress extended the coverage of the National Labor Relations Act, 29 U.S.C. 151 *et seq.*, to nonprofit hospitals. Pub. L. No. 93-360, 88 Stat. 395. In eliminating the prior statutory exemption for these institutions, Congress found "that improvements in health care would result from the right to organize, and that unionism is necessary to overcome the poor working conditions retarding the delivery of quality health care." *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 499-500 (1978). In most respects, the NLRA draws no distinction between hospitals and other employers covered by the Act. However, recognizing that "the needs of patients in health care institutions required special consideration,"¹ the 1974 amendments obligate parties to labor disputes in health care institutions to give increased notice of their intention to modify or terminate a collective bargaining agreement, to participate in meetings called by the Federal Mediation and Conciliation Service, and to give advance notice of strikes and picketing. 29 U.S.C. 158(d) (A)-(C), 158(g); see *Beth Israel Hosp. v. NLRB*, 437 U.S. at 496 & n. 12, 499.

Congress also considered, but did not enact, a bill that would have specified the bargaining units for health care institutions.² As a result, bargaining units in

¹ S. Rep. No. 766, 93d Cong., 2d Sess. 3 (1974) (reprinted in *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974*, at 10 (1974) [hereinafter 1974 *Legis. Hist.*]).

² S. 2292, 93d Cong., 2d Sess. (1973). This bill, which was introduced by Senator Taft but never reported to the floor of the Senate,

these institutions are determined—as they are for other employers—in accordance with Section 9(b) of the Act, 29 U.S.C. 159(b). This Section provides that the "Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." Although no change was made in this provision when it was extended to nonprofit hospitals in 1974, a statement admonishing the Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry" was added to the House and Senate committee reports accompanying the legislation.³

would have limited health care bargaining units to four groupings (apart from guards, who are entitled by the Act to a separate unit): all professional employees, all technical employees, all clerical employees, and all service and maintenance employees. 1974 *Leg. Hist.* 106, 108, 110.

³ S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974) (reprinted in 1974 *Legis. Hist.* 12); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974) (reprinted in 1974 *Legis. Hist.* 274-275). The statement reads in full:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).*

* By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

The addition of this language to the committee reports was part of a legislative compromise. On the floor of the Senate, Senator Taft, the

2. "Section 9(b) of the Act confers upon the Board a broad discretion to determine appropriate [bargaining] units." *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947). In exercising this discretion, the Board's focus has traditionally been on whether the employees in a proposed bargaining unit share a "community of interest" sufficient to warrant their being included in the same unit. *NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985). The Board's "primary concern" has been "to group together only those employees who have substantial mutual interests in wages, hours, and other conditions of employment" (Fifteenth Annual Report of the NLRB 39 (1950)), thereby assuring that the designated unit will be cohesive, free of undue conflicts of interest, and capable of effective bargaining. *NLRB v. Action Automotive, Inc.*, 469 U.S. at 495.

For approximately ten years following the enactment of the 1974 amendments, the Board adhered to its "community of interest" approach in resolving disputes over bargaining units in health care institutions, while seeking to avoid undue unit proliferation.⁴ However, in a large number of cases, the courts of appeals refused to uphold Board

sponsor of the bill that would have specified bargaining units for health care institutions, stated that this "agreed upon * * * report language" had been "endorsed by labor and management groups" and the Administration. 120 Cong. Rec. 12,944 (1974) (remarks of Sen. Taft) (reprinted in 1974 Legis. Hist. 112). See generally Pet. App. 8a-10a.

⁴ Some of the principal decisions explaining the evolution of the Board's approach include *Allegheny General Hosp.*, 239 N.L.R.B. 872 (1978), enforcement denied, 608 F.2d 965 (3d Cir. 1979); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409 (1980); and *St. Francis Hosp.*, 265 N.L.R.B. 1025 (1982).

determinations regarding appropriate bargaining units in those institutions.⁵ One group of courts ruled, in general, that the Board should supplement its "community of interest" approach by explaining specifically why each bargaining unit determination was consistent with the nonproliferation admonition in the 1974 committee reports.⁶ The Ninth and Tenth circuits held, however, that the admonition precluded use of the "community of interest" approach in the context of health care institutions and instead required the Board to determine whether there was a "disparity of interests" among groups of employees sufficient to justify separate bargaining units.⁷

In 1984, in its decision in *St. Francis Hosp.*, 271 N.L.R.B. 948, the Board adopted a "disparity of interest" approach for determining bargaining units in health care institutions. But on the union's petition for review, the D.C. Circuit held that the Board had erred in concluding that the admonition accompanying the 1974 amendments

⁵ In summarizing the state of the law prior to the promulgation of the regulation at issue, one commentator identified 16 decisions denying enforcement to bargaining unit determinations in the health care context. Note, *The National Labor Relations Board's Proposed Rules on Health Care Bargaining Units*, 76 Va. L. Rev. 115, 131 n.82 (1990).

⁶ E.g., *NLRB v. Mercy Hosp. Ass'n*, 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 633-635 (2d Cir. 1983); *Memorial Hosp. v. NLRB*, 545 F.2d 351, 360-362 (3d Cir. 1976); *Allegheny General Hosp. v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191, 194 (4th Cir. 1982); *Mary Thompson Hosp. v. NLRB*, 621 F.2d 858, 862-864 (7th Cir. 1980).

⁷ E.g., *NLRB v. St. Francis Hosp.*, 601 F.2d 404, 419 (9th Cir. 1979); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 810 (9th Cir. 1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457-458 n.6 (1981), modified, 688 F.2d 697 (10th Cir. 1982); *St. Anthony Hosp. Systems, Inc. v. NLRB*, 884 F.2d 518, 521 (10th Cir. 1989).

was an "independent source[] of law" that obligated the Board to adopt the "disparity of interest" test. *International Brotherhood of Elec. Workers v. NLRB*, 814 F.2d 697, 715 (1987). Further, although the court remanded to enable the Board to consider whether to adopt the "disparity of interest" approach as an exercise of its discretion, two members of the panel suggested that Congress "implicitly approved the Board's forty-year construction of section 9 to embody community-of-interest criteria" and emphasized that the Board would have to explain any departure from that approach "*adequately*," *Id.* at 711, 712 n.65; see *id.* at 718 (Buckley, J., concurring) (suggesting that the majority's observation had "ominous tones").

3. To bring order to this area, the Board, pursuant to Section 6 of the Act, 29 U.S.C. 156, published a notice of proposed rulemaking to "amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities." *Collective Bargaining Units in the Health Care Industry: Notice of Proposed Rulemaking (NPR I)*, 52 Fed. Reg. 25,142 (1987). The proposed regulation provided that, except under extraordinary circumstances, appropriate units in acute care hospitals with more than 100 beds would be limited to the following six: all registered nurses, all physicians, all professional employees except registered nurses and physicians, all technical employees, all service and maintenance and clerical employees except guards, and all guards. *Id.* at 25,146-25,148.

When it issued the proposed regulation, the Board noted that its "extensive experience" in processing "hundreds of petitions for health care units" showed that unit requests usually fell into certain predictable groups of employees that "generally exhibit the same internal characteristics, and relationship to other groups of employees, in one health care facility as do like groups of employees at

other facilities." *NPR I*, 52 Fed. Reg. at 25,143-25,144; see *id.* at 25,146-25,148. The Board emphasized, however, that it was embarking upon rulemaking in order to obtain "empirical evidence" that would better enable it "to make an informed judgment as to what units should be found appropriate in the health care industry, because they reflect true community/diversity of interests and do not promote but instead minimize the type of proliferation and interruption of care which concerned Congress in passing the 1974 amendments." *Id.* at 25,145.

The Board explained that in formulating the proposed rule it "kept firmly in mind Congress's admonition against proliferation of health care bargaining units" as well as its belief, expressed in the 1974 amendments, that collective bargaining by health care workers would "improve the quality of hospital care." *NPR I*, 52 Fed. Reg. at 25,146. The Board sought to accommodate these considerations by "limit[ing] the possible units in the various types of establishments to a reasonable, finite number of congenial groups displaying both a community of interests within themselves and a disparity of interests from other groups." *Ibid.*

After promulgating the proposed regulation, the Board conducted a series of hearings at which interested parties were given an opportunity to testify, submit evidence, and question other witnesses. The Board also received numerous written comments. *Second Notice of Proposed Rulemaking (NPR II)*, 53 Fed. Reg. 33,900 (1988). With the benefit of these submissions, the Board issued an amended proposal and invited additional comments. On April 21, 1989, after reviewing the many comments submitted in response, the Board made further modifications and issued the regulation at issue here. 29 C.F.R. 103.30. See 54 Fed. Reg. 16,336-16,348 (1989).

Based upon evidence acquired during the rulemaking, the Board determined that, in addition to the units first proposed, separate bargaining units should be recognized for business office clerical workers and for skilled maintenance employees. See *NPR II*, 53 Fed. Reg. at 33,920-33,927, 33,933-33,934. Thus, absent "extraordinary circumstances," the final regulation permits recognition of eight specified bargaining units in all "acute care hospitals": all registered nurses, all physicians, all other professionals, all technical employees, all skilled maintenance employees, all business office clerical employees, all guards, and all other nonprofessional employees. 29 C.F.R. 130.30(a).⁸ The fact that a disputed unit would include five or fewer employees is an "extraordinary circumstance" requiring resolution through adjudication. *Ibid.* In other respects, the Board has made clear its intention to construe the extraordinary circumstances exception narrowly—in general, to require a showing of circumstances other than those that the rulemaking demonstrated to be insufficient to foreclose adoption of a uniform rule. *NPR II*, 53 Fed. Reg. at 33,932-33,933; see 54 Fed. Reg. at 16,344-16,345.

⁸ Institutions that are primarily nursing homes, psychiatric hospitals, or rehabilitative hospitals are excluded from the regulation. 29 C.F.R. 103.30(f). See *NPR II*, 53 Fed. Reg. at 33,927-33,929; 54 Fed. Reg. at 16,342-16,344, 16,348. The Board determined that the 100-bed limitation contained in the first proposed regulation was not useful because it did not correlate to issues relevant to unit determination and the parties were generally opposed to use of a distinction based on number of beds. *NPR II*, 53 Fed. Reg. at 33,927. The regulation allows the parties to stipulate to a unit not conforming to those set forth, 29 C.F.R. 103.30(d), and provides that, if sought by a union, various combinations of the eight units may be appropriate, 29 C.F.R. 103.30(a). Where there are pre-existing nonconforming units at an acute care hospital, the regulation will be applied insofar as practicable. 29 C.F.R. 103.30(c).

In determining the units that would be recognized, the Board chose not to apply either a strict "community of interests" or "disparity of interests" approach. *NPR II*, 53 Fed. Reg. at 33,905. Rather, it sought to base its bargaining unit determinations on available empirical evidence. Its goal was "to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes." *Id.* at 33,905. To that end, the Board canvassed factors similar to those considered under both the "community of interest" and "disparity of interest" approaches. See *id.* at 33,911-33,927; 54 Fed. Reg. at 16,340-16,341.

The Board found no merit in the objections to the regulation on which petitioner relies in this Court. First, the Board rejected the contention that, in directing the Board to determine the appropriate unit "in each case," Section 9(b) of the NLRA precludes adoption of a regulation specifying the bargaining units appropriate in health care institutions. *NPR I*, 52 Fed. Reg. at 25,144; *NPR II*, 53 Fed. Reg. at 33,901; 54 Fed. Reg. at 16,337-16,338. Second, in justifying its final regulation, the Board expressly determined that each of the units it had recognized, and the scheme viewed as a whole, were consistent with the concern expressed in the 1974 admonition. *NPR II*, 53 Fed. Reg. at 33,916, 33,917, 33,918, 33,920, 33,922, 33,926, 33,933-33,934; 54 Fed. Reg. at 16,345-16,346. Finally, the Board found that it would not be arbitrary to prescribe bargaining units for all acute care hospitals. Citing testimony by an industry spokesperson, the Board determined

that diversity among institutions covered by the regulation was not "shown to be sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate bargaining units * * * in all but truly extraordinary facilities." *NPR II*, 53 Fed. Reg. at 33,903; see *NPR I*, 52 Fed. Reg. at 25,143-25,144.⁹

4. Petitioner American Hospital Association challenged the regulation on its face in a suit filed in the United States District Court for the Northern District of Illinois. The district court concluded that the "in each case" language of Section 9(b) of the NLRA did not foreclose the Board from using rulemaking in determining appropriate bargaining units. Pet. App. 35a. However, the court ruled that the admonition accompanying the 1974 amendments required the Board to "use the means least likely to cause unit proliferation to achieve [its] objective." *Id.* at 38a. Although conceding that the units designated by the Board "are appropriate," the court observed that it could "envision other divisions, perhaps fewer divisions, in the varied health institutions which would be equally reasonable" and thus held that the regulation was not "responsive" to the admonition. *Id.* at 38a, 41a. The court enjoined implementation of the regulation. *Id.* at 42a.¹⁰

⁹ Board Member Johansen dissented from the orders promulgating the amended proposed regulation and the final regulation. *NPR II*, 53 Fed. Reg. at 33,934-33,935; 54 Fed. Reg. at 16,347. In his view, the "in each case" language in Section 9(b) of the Act forecloses establishing bargaining units through rulemaking and, in any event, rulemaking in this area was not necessary or desirable. *Ibid.*

¹⁰ In the district court, the Board argued that the court lacked jurisdiction to review the regulation, either because (like a Board certification of an appropriate bargaining unit) it is not a final order within the scheme of the NLRA, see *Boire v. Greyhound Corp.*, 376 U.S. 473

5. The court of appeals reversed, vacated the district court's injunction, and directed entry of judgment for the Board. Pet. App. 1a-16a. The court of appeals rejected petitioner's contention that Section 9(b) of the NLRA mandates "that the Board must determine the appropriate unit on a case by case basis, except for the irreducible minimum of three units authorized by the statute itself." Pet. App. 6a. Citing several alternative interpretations of the statute, the court determined that the language and legislative history do not support petitioner's construction. Finding "no reason why Congress might have wanted to carve out unit determinations from the grant of rulemaking power in section 6 and no indication beyond the ambiguous semantics of the word 'case' that it did want to do this," the court concluded "that unit determinations [are] not excepted from the Board's power under that section." *Id.* at 8a.

The court of appeals also held that the Board's regulation does not contravene the undue-proliferation admonition accompanying the 1974 amendments. The court noted that the industry had failed in its attempts to obtain legislation limiting the number of bargaining units in health care institutions. Pet. App. 9a. It then concluded that the admonition "is entitled to our respectful consideration, not only for its intrinsic merits but also for what light it sheds on Congress's intentions in the 1974

(1964); *Leedom v. Kyne*, 358 U.S. 184 (1958); *American Fed'n of Labor v. NLRB*, 308 U.S. 401 (1940), or because the case was not ripe within the meaning of *Abbott Laboratories v. Gardner*, 387 U.S. 136, 148-156 (1967), and its progeny. The district court rejected these contentions, determining that it had jurisdiction to pass on petitioner's challenges to the regulation and that the immediate impact of the regulation on organizational activities warranted preliminary (and later permanent) injunctive relief. The Board did not raise in the court of appeals, and does not raise here, any question of reviewability.

amendments," but is "not an amendment to section 9(b), decreeing that in the health-care industry no more than three separate bargaining units shall be authorized." *Id.* at 12a. The court added that the admonition would not foreclose the Board's eight-unit regulation "even if it were a statute, rather than a statement in committee reports" (*ibid.*). Finding that concern over proliferation had focused on "finer divisions of the health-care work force than attempted in the rule under challenge" (*id.* at 14a), the court determined that "neither the cases cited in the admonition nor the admonition itself reads on the issue of the propriety of eight units" (*id.* at 13a).

Finally, the court rejected petitioner's contention that the Board's regulation "is arbitrary because it lumps together hospitals of different sizes and missions in different locations" (Pet. App. 14a). The court observed that the very nature of a regulation is to make "one or a few of a mass of particulars legally decisive, ignoring the rest"; the "result is a gain in certainty, predictability, celerity, and economy, and a loss in individualized justice" (*id.* at 15a). Here, the court continued, the Board considered alternatives to the regulation it had chosen and "gave plausible reasons for its choice." *Id.* at 16a. The court added that the "decision how complex to make a rule—that is, how many exceptions to recognize—is judgmental," and it "is not for [courts] to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions than it does, or slightly fewer." *Ibid.* The court concluded (*ibid.*):

The Board did a responsible job of weighing the conflicting arguments, and we therefore uphold its rule without pretending that we consider it Utopia.

The court of appeals subsequently granted petitioner's motion to stay issuance of the mandate pending the filing and disposition of a petition for certiorari. During the 15-

month period that implementation of the regulation has been enjoined, the Board has deferred action on all representation petitions seeking elections in units where the outcome would be affected by the regulation.

ARGUMENT

1. Sixteen years after Congress extended the NLRA to include nonprofit hospitals, the appropriate scope of health care bargaining units in those institutions remains unsettled. After its efforts to formulate doctrinal solutions to these issues had been rejected in numerous, often conflicting, decisions by courts of appeals, the Board acted decisively to end this uncertainty by promulgating a regulation establishing bargaining units in a specified category of health care facilities. Based on the information obtained in the rulemaking proceeding, the Board concluded that bargaining units for acute care hospitals should be established by general rule; that the eight units specified in its regulation would effectuate the right of employees in acute care hospitals to organize and bargain collectively without resulting in undue proliferation or associated evils; and that, save in extraordinary circumstances (for instance, a unit of five or fewer employees), these eight units were the units appropriate in all acute care hospitals.

For essentially the reasons stated in the court of appeals' decision, we believe that the Board acted within the scope of its authority in promulgating the regulation and that application of the regulation to all acute care hospitals cannot fairly be characterized as arbitrary or capricious. As petitioner acknowledges (Pet. 13), Section 9(b)'s provision that the Board determine the appropriate bargaining unit "in each case" does not preclude the Board from establishing rules of decision to be applied in those cases—either in the course of adjudications or through rulemaking. Within broad limits, the choice between rule-

making and adjudication and the specificity of the rules governing bargaining unit determinations are matters within the Board's discretion. See, e.g., *Packard Motor Car Co. v. NLRB*, 330 U.S. at 491; *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 293-295 (1974). See also *Heckler v. Campbell*, 461 U.S. 458 (1983); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). The regulation at issue falls well within the boundaries of that discretion.

Nor does the admonition accompanying the 1974 amendments provide any basis for invalidating the Board's regulation. The admonition was not enacted into law and does not, therefore, limit the scope of the Board's rulemaking authority. Even if that were not so, the admonition would mandate only "due consideration" of proliferation of bargaining units. The Board's painstaking attention to this issue in the rulemaking proceeding—attention prompted not only by the concern expressed in the admonition, but also by the Board's "own view of what is appropriate in the health care industry," *NPR II*, 53 Fed. Reg. at 33,905—forecloses any claim that the Board's consideration of the issue of proliferation has been insufficient. See pp. 7-9, *supra*. Further, as the court of appeals noted, the units to which the admonition referred were narrower and thus more numerous than those contemplated by the Board's regulation. See Pet. App. 12a-14a.

Finally, the decision to apply the regulation to all facilities falling within the regulation's definition of "acute care hospital" is amply supported by the administrative record and is not arbitrary and capricious. In the course of the rulemaking proceeding, the Board eliminated a proposed 100-bed limitation on its regulation in response to industry criticism and added an express exception for bargaining units with five or fewer employees. The Board refined its definition of "acute care hospital" and excluded certain

categories of facilities—nursing homes, psychiatric hospitals, and rehabilitative facilities—in recognition of distinctions between these institutions and hospitals covered by the regulation. The "extraordinary circumstances" exception remains available to institutions capable of demonstrating that considerations not addressed in the rulemaking proceeding warrant a departure from the units specified by the regulation. The regulation was amply justified and explained.

2. While we believe that the court of appeals' decision is correct, we do not oppose review of that decision in this Court. It is critical to the administration of the Act and to labor-management relations in the many acute care hospitals covered by the Act that the validity of the Board's regulation be definitively resolved at the earliest possible date. As one commentator has aptly observed, this area has been characterized by a "conceptual World War I that has prevented stable rules from emerging." 4 T. Kheel, *Labor Law* § 14.03[7] (1989). Absent prompt review by this Court, it is inevitable, as petitioner asserts (Pet. 11, 29-30), that the regulation will be challenged in other circuits, through district court suits and by way of defense to Board bargaining orders issued in individual cases.¹¹ This additional litigation would exact a heavy toll on the resources of the courts, the Board, and the parties. In particular, employees in acute care hospitals who seek to exercise their rights to organize and bargain collectively

¹¹ In our view, petitioner's members would be collaterally estopped from relitigating issues decided in this case. See *Western Coal Traffic League v. ICC*, 735 F.2d 1408, 1411 (D.C. Cir. 1984) (and cases cited therein). However, the extent to which members of an association may be subject to collateral estoppel in these circumstances is not fully settled, see 18 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 4456 (1981 & 1990 Supp.), and, in any event, the Board's regulation would be subject to challenge by hospitals that are not members of petitioner.

through representatives of their own choosing—activities that Congress concluded in 1974 would advance not only the interests of employees, but of patients as well—will be forced to bear additional delay and expense.

Moreover, reasoning in prior decisions of other courts of appeals is inconsistent, at least in principle, with the Seventh Circuit's decision to uphold the Board's regulation. The Seventh Circuit has effectively held that the admonition accompanying the 1974 amendments does not foreclose a decision to employ rulemaking; that the Board satisfied the concerns underlying the admonition in its extensive rulemaking proceeding; and that the admonition refers in any event to bargaining units that are smaller and more specialized than those recognized in the Board's regulation. Pet. App. 13a. By contrast, certain decisions of the Ninth and Tenth Circuits suggest that the admonition requires consideration of the particular facts of each proposed bargaining unit. In *NLRB v. St. Francis Hospital*, 601 F.2d 404, 416 (1979), the Ninth Circuit stated that the "due consideration" referred to in the admonition "demands individual examination by the Board, or its delegate, of the circumstances of each particular case in order to determine the propriety of the proposed unit in light of the congressional directive and the public interest." The Tenth Circuit, in *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (1981), ruled that "any use of a presumption which casts upon [the hospital] the burden of producing evidence of the inappropriateness of the unit violates Congress' directive of non-proliferation in the health care industry." Moreover, the decisions in both *St. Francis* and *Presbyterian/St. Luke's* held that the 1974 admonition obligates the Board, in health care institutions, to select the broadest possible units—excluding only those employees with disparate interests. 601 F.2d at 419; 653 F.2d at 457-458 n.6. The ap-

proach that the Board followed in formulating its regulation (see *NPR II*, 53 Fed. Reg. at 33,904-33,906) might be regarded as inconsistent with that model.

* * * * *

The questions presented in the petition raise issues appropriate for consideration by this Court. And in our view, the Court's consideration would not benefit from further litigation in the courts of appeals. Accordingly, we do not oppose review of the court of appeals' decision by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.
Respectfully submitted.

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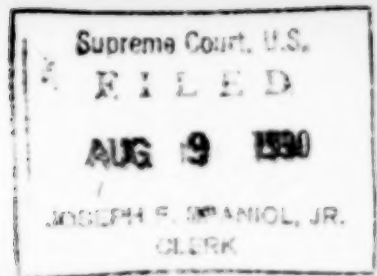
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SEPTEMBER 1990

③
No. 90-97



IN THE
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

On Petition For A Writ Of Certiorari To The United
States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF THE FAIRFAX HOSPITAL
SYSTEM IN SUPPORT OF THE PETITION

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IN THE
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

AMICUS CURIAE BRIEF OF THE FAIRFAX HOSPITAL
SYSTEM IN SUPPORT OF THE PETITION

INTEREST OF THE AMICUS CURIAE

The Fairfax Hospital System submits its brief as *amicus curiae* in support of the petition for writ of certiorari of the American Hospital Association.¹ Petitioner in this matter challenges the legitimacy under applicable law of the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry (hereinafter "Final Rule" or "the Rule"). 54 Fed. Reg. 16347-16348, 29 C.F.R. § 103.30 (1989). The Fairfax Hospital System believes it can illuminate the disruption and associated costs that will occur if the Seventh Circuit's decision vacating the injunction against the Rule is allowed to stand. The *amicus curiae* brief will demonstrate the practical impact of the Board's Final Rule on acute care hospitals throughout this country.

¹ All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

The Fairfax Hospital System consists of four affiliated nonprofit hospitals located in the Washington, D. C. suburbs of Northern Virginia. The hospitals include: (1) Fairfax Hospital, located in Falls Church, Virginia; (2) Fair Oaks Hospital, located in Fairfax, Virginia; (3) Jefferson Hospital, located in Alexandria, Virginia and (4) Mount Vernon Hospital, also located in Alexandria, Virginia. The Fairfax Hospital System employs over 7,000 health care workers. The largest of the hospitals in the System is Fairfax Hospital with over 4,500 employees. Mount Vernon Hospital has approximately 1,200 employees, whereas Fair Oaks Hospital has over 850 employees. Jefferson Hospital is the smallest of the hospitals within the Fairfax Hospital System and it employs approximately 420 individuals. The four hospitals, despite a great disparity in size and complexity of organization, all come within the definition of "acute care" hospital as set forth in the Board's Final Rule.

All employees of the Fairfax Hospital System are currently nonunion. On January 17, 1990, however, a petition was filed in Region 5 of the National Labor Relations Board ("NLRB") by the District of Columbia Nurses Association ("DCNA"). By this petition, designated Case No. 5-RC-13331 by the NLRB, the DCNA seeks to represent a unit of approximately 1,200 registered nurses within Fairfax Hospital. The Regional Director for Region 5 has been prevented from taking any action on the petition because of the injunction issued by the United States District Court for the Northern District of Illinois on July 25, 1989. The United States Court of Appeals for the Seventh Circuit vacated the injunction against enforcement of the Board's Final Rule on April 11, 1990. The American Hospital Association gained a stay of that order pending the petition to the United States Supreme Court for a writ of certiorari.

If the writ of certiorari is not granted, however, it is expected that Region 5 will move quickly to apply the Board's Final Rule to the petition filed by the DCNA and certify the proposed unit of registered nurses as an appropriate bargaining unit without considering the special facts of employment at Fairfax Hospital. Without review by the Supreme Court, Fairfax Hospital will be precluded from exploring the appropriateness of alternative bargaining units at Fairfax Hospital during the representation proceeding. The Seventh Circuit's decision to dissolve the injunction against the Board's Final Rule also raises

the specter of 32 possible units within the Fairfax Hospital System, the potential for jurisdictional disputes between unions competing for membership within the System, and the potential for dramatic increases in administrative costs for the Fairfax Hospital System as a consequence of having to negotiate and administer contracts with many different unions within the Fairfax Hospital System.

The potential fragmentation of its work force is particularly alarming to Fairfax Hospital because it operates a highly integrated work force with a great degree of contact between registered nurses and other allied professionals. The Hospital utilizes a team approach to health care. The Hospital is organized along service department lines rather than artificially according to the various professions working within the facility. The Hospital's registered nurses work side-by-side with emergency room physicians, respiratory therapists, physical therapists, dieticians, occupational therapists, pharmacists, social workers, respiratory technicians, registered medical technologists and x-ray technicians. Many of these allied professionals have common management and supervisory personnel. They have similar education, training and licensing requirements. Their salaries are comparable and they participate in common benefit plans of the Fairfax Hospital System.

The Fairfax Hospital System believes the determination of an appropriate bargaining unit for any group of organized employees at Fairfax Hospital must take into consideration the integrated nature of the Hospital's staff. Applicable decisions of the Fourth Circuit have favored a case-by-case approach to bargaining unit determinations by the NLRB and due consideration of the congressional admonition against proliferation of bargaining units in the health care industry. *See NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982). Application of the Board's Final Rule to the DCNA petition will preclude any litigation of the appropriateness of an alternative bargaining unit at the administrative level. In order to obtain consideration of the special nature of employment at Fairfax Hospital, the Hospital would be forced to challenge the appropriateness of the unit before the Fourth Circuit. Thus, unless the issue of the legitimacy of the Board's Final Rule is resolved now by the Court, Fairfax Hospital System faces the possibility of extended litigation over the application of the Rule to one or more of its hospitals.

The Fairfax Hospital System is, thus, vitally interested in the issues presented by this case and it supports a resolution of these issues at this time so that Fairfax Hospital and the Fairfax Hospital System can accurately weigh their legal and administrative options in response to the current organizing petition and the other potential petitions within the Fairfax Hospital System.

STATEMENT

As set forth in detail by the American Hospital Association in the Petition for a Writ of Certiorari, this case presents the important issue of whether the NLRB will be allowed to promulgate and apply a rule mandating that only eight bargaining units are appropriate within acute care hospitals regardless of their size, location or differences in their operations. See Petition for a Writ of Certiorari; (hereinafter "Pet."), pp.2-3. The Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, and its *per se* application to all representation petitions relating to acute care hospitals, including the petition for representation of registered nurses at Fairfax Hospital, raises substantial and difficult legal questions requiring this Court's review. Specifically, is the Final Rule contrary to the congressional admonition contained in the legislative history of the Health Care Amendments Act of 1974? Is it in conflict with Section 9(b) of the National Labor Relations Act which requires the Board to decide appropriate bargaining units "in each case"? 29 U.S.C. § 159(b).

The Board's Final Rule provides for eight bargaining units within acute care hospitals. This is true regardless of the size or complexity of operations of any particular hospital. The Rule makes clear that the eight appropriate units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units mandated by the Rule include: (1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16347-16348, 29 C.F.R. § 103.30; see also Appendix to the Petition for Writ of Certiorari (hereinafter "Pet. App."), p.44a.

The Board's "extraordinary circumstances" exception is extremely narrow. The Board has stated that it will not consider additional evidence or arguments that a particular hospital varied from the norm, even if the variation is "highly unusual". See Second Notice of Proposed Rule Making ("NPR II"), 53 Fed. Reg. 33932-33933 (1988); Pet., p.9. Hospitals bear a "heavy burden" to demonstrate that extraordinary circumstances exist which make the *per se* Rule inappropriate. *Id.* at 33933. In particular, the Board has stated that "increased functional integration of and a higher degree of work contacts between, employees as a result of the advent of a multi-competent worker, increased use of 'team' care and cross training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. *Id.*

Petitioner in this case, American Hospital Association, challenged the Final Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court issued a permanent injunction barring its enforcement. *American Hospital Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule was in conflict with the congressional admonition to give due consideration to undue proliferation of bargaining units in the health care industry. The court said:

A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

Pet. App. at 41a-42a.

The district court did not decide the question of whether the Board's Final Rule was also precluded by the requirement of Section 9(b) of the Act to determine the appropriate bargaining unit "in each case". 29 U.S.C. § 159(b). Nor did the district court address the

American Hospital Association's claim that the Rule was "arbitrary, capricious and not supported by the evidence." Pet., p.10.

Respondents appealed the district court's decision to the Seventh Circuit Court of Appeals. In *American Hospital Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed the decision of the district court and vacated the injunction. Pet. App. at 16a. The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case-by-case determination of bargaining units. The court also held that the Rule was not precluded by the congressional admonition against proliferation of units in the health care field. Finally, the court of appeals rejected the American Hospital Association's argument that the Final Rule was arbitrary and capricious because it failed to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 14a; *see also* Pet., pp.10-11.

In reaching its decision, the Seventh Circuit made no attempt to distinguish decisions of other courts of appeals which have rejected *per se* rules dealing with the appropriateness of a bargaining unit in any particular industry. For example, in *NLRB v. Frederick Memorial Hosp., Inc.*, 691 F.2d 191 (4th Cir. 1982), the Fourth Circuit denied enforcement of a Board order finding a bargaining unit composed of all registered nurses to be appropriate because the Board had considered the appropriateness of the registered nurses unit without addressing the question of unit proliferation. The Fourth Circuit said:

[T]he Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination...implement[s] or reflect[s] that admonition...."

691 F.2d at 194.

On May 2, 1990, the Court of Appeals for the Seventh Circuit granted the American Hospital Association's motion to stay the issuance of the mandate pending the outcome of the petition for a writ of certiorari. Pet., p.11.

REASONS FOR GRANTING THE PETITION

The Seventh Circuit's decision in *American Hospital Ass'n v. NLRB* will have a direct and immediate effect on the Fairfax Hospital System. If the decision is allowed to stand, the Board will no longer be prohibited from applying its Final Rule to representation petitions within the health care industry. The Board will undoubtedly approve the DCNA's petition for an all RN unit at Fairfax Hospital without considering the special facts of employment at Fairfax Hospital. Contrary to the Fourth Circuit's direction in its *Frederick Memorial Hospital* decision, the Board will also not determine whether the application of the Rule would result in an unnecessary proliferation of units within Fairfax Hospital and ultimately within the Fairfax Hospital System. Unless the issue of the legitimacy of the NLRB's Final Rule is resolved at this time, Fairfax Hospital, if it wants the special circumstances of employment at the Hospital to come to light, will be forced to challenge the application of the Rule in litigation before the Fourth Circuit. The cost of any such challenge will work a heavy burden on the Fairfax Hospital System and would be an unnecessary utilization of resources of the court of appeals. Labor relations at the Hospital would be needlessly disrupted while the Fourth Circuit challenge proceeds. A decision by the Court to grant certiorari and resolve the question of the legitimacy of the Board's Final Rule now will avoid this waste of resources and resolve the conflict that exists at this time between the courts of appeals.

Even if Fairfax Hospital does not challenge the Board's Rule before the Fourth Circuit, the application of the Rule to the pending petition of the DCNA forecloses the possibility that a bargaining unit other than an all RN unit will be considered as appropriate for bargaining at Fairfax Hospital. The result will be an unnecessary fragmentation of employees within the Hospital with registered nurses governed by different work rules than those applied to other professionals within the Hospital. The Hospital will be required to administer different rules, wages and benefits for professionals working side by side. Union stewards with divided loyalties will be forced to police the assignment of work to ensure that their particular union preserves its share of the wages and hours needed to deliver health care at the Hospital. Should different unions organize separate groups

of employees at Fairfax Hospital along the lines suggested by the Final Rule, the contracts dealing with all such relationships between the Hospital and the unions will likely expire at different times. Negotiations will also occur at different intervals. The Fairfax Hospital System's goal of coordinated delivery of health care will likely be thwarted by internal disputes between unions. Delivery of health care to Fairfax Hospital's patients will not be as efficient and may result in unnecessary harm to these patients.

Application of the Rule to the Fairfax Hospital System could ultimately result in 32 different units within the System's four hospitals. The result will be a proliferation of units which can be avoided now by a decision by this Court. Even assuming the Court resolves the question of the legitimacy of the Board's Rule in a manner adverse to the American Hospital Association's position, Fairfax Hospital System can avoid potential legal costs in the Fourth Circuit (and the disruption of labor relations such an appeal might cause) and plan for the segmentation that could occur in its work force.

I. THE SEVENTH CIRCUIT'S DECISION IS IN CONFLICT WITH APPLICABLE LAW IN THE FOURTH CIRCUIT

The Fairfax Hospital System, located as it is within Northern Virginia, must regulate its labor relations policies in accordance with the National Labor Relations Act as interpreted by the National Labor Relations Board *and* as enforced by the Fourth Circuit. Although the Seventh Circuit's decision in this case would allow the Board to apply its Final Rule to petitions for representation in health care institutions, Fairfax Hospital is entitled to challenge bargaining unit determinations in the Fourth Circuit if it believes the Board's decisions are not consistent with applicable law.

The Fourth Circuit has always required a case-by-case determination as to the appropriate bargaining unit in any particular facility. Additionally, the Fourth Circuit requires each unit determination to reflect the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". In *NLRB v. Frederick Memorial Hospital*,

the NLRB sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The Court of Appeals rejected the Board's findings because the NLRB did not give due consideration to the issue of proliferation of bargaining units at the Hospital. 691 F.2d at 194.

The Board's decision, *Frederick Memorial Hospital, Inc.*, 254 NLRB 36 (1981), upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interest, separate and apart from all other professionals, to justify their own unit for bargaining purposes. Finding differences in licensure and training requirements, vacation pay, overtime payments, organizational structure, and other working conditions between the registered nurses and the other professionals, the Regional Director concluded that a separate unit of nurses was appropriate. In particular, the Board emphasized the fact that the vast majority of the registered nurses at Frederick Memorial Hospital were administratively separated into a nursing division which promulgated its own work policies and procedures. The registered nurses reported to different supervisors than the other professionals at the hospital and they also lacked extensive contact with other professionals. 254 NLRB at 38.

The NLRB thus rejected the hospital's attempt to include thirty-six other health care professionals into the unit of 158 registered nurses. The NLRB also rejected, however, language in the Regional Director's decision which suggested that the RN unit sought by the union was "*per se* appropriate". The Board stated:

We do not rely on, however, any comments in the Regional Director's decision that may be taken as a conclusion that the registered nurse unit sought here was *per se* appropriate. Our conclusion on the appropriateness of the unit is based on *the particular circumstances involved here*.

Id. at 39, n.12 (emphasis added).

As reported, the Board's decision in *Frederick Memorial Hospital* illustrates that the Regional Director made a detailed analysis of the working conditions of the registered nurses and the other allied

professionals at the hospital before concluding that the RN unit was appropriate. The Board said:

Here, while the Regional Director issued his decision in the underlying representation case without the benefit of *Newton-Wellesley*, he did receive and consider all the evidence presented by the parties concerning the alleged appropriateness of the petitioned-for unit of registered nurses. Here, unlike the situation in *St. Francis Hospital of Linwood*, all parties at the hearing in the representation case encouraged the taking of testimony concerning the appropriateness of a registered nurse unit. With all evidence having been adduced that the parties deemed relevant, the Regional Director in his decision then concluded that the requested unit of registered nurses here was an appropriate unit for collective bargaining.

Id. at 37.

The *Frederick Memorial Hospital* decision demonstrates that both the Regional Director and the Board analyzed the working conditions within the hospital in detail before concluding that the unit of registered nurses was appropriate. The Court of Appeals for the Fourth Circuit approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

The Board may not depend solely on the traditional community of interest test when making a unit determination for health care institution employees. As other courts have held, the Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination... implement[s] or reflect[s] that admonition...."

A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the Court adequately review the Board's decision and order unless the Board clearly discloses why certification of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194. (citations omitted).

The Fourth Circuit recognized in its *Frederick Memorial Hospital* decision that a unit of registered nurses might not be appropriate in other hospitals. *Id.* In this respect, the Fourth Circuit's opinion is clearly at odds with the Seventh Circuit's decision sanctioning the Board's new *per se* approach for bargaining unit determinations. Similarly, the Fourth Circuit requires consideration of the congressional admonition against proliferation in each unit determination and a specific explanation of why certification of a particular unit in each case serves the Congressional admonition against unit proliferation. This holding of the Fourth Circuit is again clearly at odds with the Seventh Circuit's decision. See Pet. App. at 12a. ("[The admonition] is cautionary rather than directive.").

The rights of Fairfax Hospital System with respect to arguing the appropriateness of any bargaining unit within the Fairfax Hospital System is thus governed by the Fourth Circuit's decision in *Frederick Memorial Hospital*. The Board's Final Rule would preclude the kind of specific case-by-case analysis required by the Fourth Circuit in *Frederick Memorial Hospital*. Fairfax Hospital would not be bound by the Seventh Circuit's decision, however, but would be entitled to challenge in the court of appeals the appropriateness of any unit which is determined to be *per se* appropriate pursuant to the Board's Final Rule. A decision now by the Court resolving the conflict between the courts of appeals would, therefore, prevent the needless waste of time and resources of the Fairfax Hospital System, the DCNA, the Board and the Fourth Circuit.

II. THE BOARD'S RULE IS ARBITRARY AND CAPRICIOUS INsofar AS IT IGNORES THE PARTICULAR CONDITIONS OF EMPLOYMENT WITHIN FAIRFAX HOSPITAL AND THE DIFFERING SIZE, LOCATIONS AND OPERATIONS OF OTHER HOSPITALS WITHIN THE FAIRFAX HOSPITAL SYSTEM.

The Board's Final Rule mandates that the petition for an all RN unit at Fairfax Hospital be approved by the Regional Director for the NLRB without a specific analysis of employment conditions at Fairfax Hospital. If the union is successful in convincing registered nurses to vote for representation, Fairfax Hospital will be faced with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at Fairfax Hospital. The result will be a fragmentation of the work force, with some professionals working under work rules governed by the collective bargaining agreement, while others working under the policies of the Fairfax Hospital System.

Fairfax Hospital has instituted a team approach to medical care within the Hospital and it has integrated the services of its professionals in implementing this approach. The Board's Final Rule would set registered nurses apart in an artificially created labor relations unit that will undoubtedly impede the coordinated delivery of health care envisioned by the Fairfax Hospital organization. Work rules developed out of the negotiations between the union and the Hospital may also conflict with the integrated team approach utilized by the Hospital at this time. Ultimately, if the Board's *per se* Rule is allowed to stand, the Hospital may have to deal with eight separate units of employees, all working under separate contracts with separate work rules, with separate salary structures, with separate benefit plans, all of which will be monitored and patrolled by cadres of union stewards. The Fairfax Hospital System believes that such a proliferation of units is an unnecessary consequence of the union organizing which is now occurring at Fairfax Hospital. The Fairfax Hospital System believes that its integrated organizational structure merits consideration of other possible bargaining units by which the desire for union repre-

sentation, such as it may exist, can be accommodated in a coordinated and reasonable manner.

The Fairfax Hospital System urges the Court to consider whether the Board's Final Rule gives the System any realistic opportunity to demonstrate that its coordinated approach to health care delivery is better served by bargaining units other than the eight rigid groupings set forth in the Final Rule. For example, registered nurses at Fairfax Hospital are not set apart into a separate nursing division as was the case in the *Frederick Memorial Hospital* decision. Nurses are assigned to various specialty areas and they report to assistant administrators who also supervise the work of other allied professionals at the Hospital. Nurses also work along side other professionals in departments where the immediate supervisor is not a registered nurse. For example, the director of cardiovascular services supervises nurses and cardiovascular technologists. The radiation therapy director supervises nurses and radiation therapy technicians. The radiology director supervises both nurses and x-ray technicians. Laboratory directors supervise nurses and medical technologists.

The Hospital also has mechanisms in effect for increasing the integration between professionals and the delivery of coordinated health care services to its patients. For example, delivery of emergency care is very much a team effort with nurses, physicians and x-ray technicians treating the same patient. Pharmacists are assigned to nursing units in various satellite pharmacies to increase coordination and delivery time of medicine to the Hospital's patients. Nurses work with pharmacists and dieticians on nutrition support teams to assist the recovery of patients. Finally, discharge planning is also a team effort with social workers, physicians and nurses working together prior to the actual release of patients.

It is easy to visualize how Fairfax Hospital's team approach to patient care will be disrupted by the *per se* application of the Board's Final Rule. The Final Rule forces professionals working on the same hospital team into separate units for bargaining. The Rule also increases the likelihood that these professionals will be represented by different unions. The Hospital's team concept could be threatened by jurisdictional disputes over which work will be performed by which union. Conflicting work rules regarding hours of work, overtime and

other working conditions are likely to destroy the cohesion of the Hospital's integrated approach to patient care. Ultimately, patient care may be impaired by the conflict between union members, thereby creating the very situation which Congress attempted to prevent in drafting the Health Care Amendments Act.

The Board's Final Rule ignores the special circumstances of employment at Fairfax Hospital and threatens to disrupt the Hospital's team concept for delivering quality health care at the institution. The Board's "extraordinary circumstances" exception will not provide the opportunity Fairfax Hospital needs to demonstrate to the NLRB that bargaining units other than those set forth in the Rule may better suit the special needs of the Hospital.

The dilemma for the Fairfax Hospital System is likewise ominous if the Board's *per se* rule is allowed to have application to all of the hospitals within the System without an individual analysis of the merits of any particular bargaining unit at each hospital. The Board's Final Rule presents the potential for 32 different bargaining units within the Fairfax Hospital System. This is true even though the hospitals vary in size from 4,500 employees at Fairfax Hospital to only 420 employees at Jefferson Hospital. This is true even though the delivery of patient care services varies from hospital to hospital and the range of services offered obviously is much more complex and varied at Fairfax Hospital than can be achieved at Jefferson Hospital. Even assuming an all RN unit was appropriate at Fairfax Hospital, a similar fragmentation of the professional work force at Jefferson Hospital would not necessarily be appropriate. The Board's Rule mandates such fragmentation, nevertheless.

The Fairfax Hospital System applies the same benefit plans, personnel policies and salary scales to all employees in the System. The cost to the Fairfax Hospital System of restructuring its benefit plans, its salary scales, and its personnel policies to accommodate 32 different bargaining units would be enormous. The Board's Final Rule is arbitrary and capricious in that it fails to recognize the differences between the various hospitals within the Fairfax Hospital System and precludes any particular hospital from arguing the reasonableness of a lesser number of bargaining units than that which is mandated by the Board's Final Rule. The potential problems and disruption which

would likely be experienced within the Fairfax Hospital System will reoccur within other hospital systems unless the Court overturns the Seventh Circuit's decision and reinstates the injunction ordered by the district court. A decision on the legitimacy of the Board's Rule is needed now before costs and disruption begin escalating for the Fairfax Hospital System and other health care institutions in this country.

CONCLUSION

For all the foregoing reasons and for the reasons stated in the petition of the American Hospital Association, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

By: _____

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The Fairfax Hospital System

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APPENDIX

1a

July 12, 1990

BY FEDERAL EXPRESS

Paul M. Lusky
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*

Dear Paul:

The American Hospital Association consents to your filing a brief *amicus curiae* in this matter on behalf of the Fairfax Hospitals.

Sincerely,

James Holzhauser

JDH:cml
Enclosures

2a

U.S. Department of Justice
Office of the Solicitor General

July 27, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

Re: *American Hospital Association v. N.L.R.B., et al.*,
No. 90-97

Dear Mr. Lusky:

In response to your letter of July 17, 1990, I hereby consent to the filing of an *amicus curiae* brief on behalf of the Fairfax Hospital System.

Sincerely,

Kenneth W. Starr
Solicitor General

3a

July 18, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

Re: *American Hospital Association v. N.L.R.B., et al.*,
United States Supreme Court (Oct. Term, 1990)

Dear Mr. Lusky:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of the Fairfax Hospital System.

Sincerely,

George Kaufmann

4a

July 30, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

Re: *American Hospital Association v. N.L.R.B., et al.*,
(United States Supreme Court, October Term,
1990)

Dear Mr. Lusky:

The AFL-CIO, Building and Construction Trades Department
consents to your filing of an *amicus curiae* brief in the above-refer-
enced matter on behalf of the Fairfax Hospital System.

Sincerely,

David Silberman

In the Supreme Court

OF THE United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,

VS.

NATIONAL LABOR RELATIONS BOARD, Et Al.,
Respondents.

On Petition for Writ of Certiorari to
the United States Court of Appeals
for the Seventh Circuit

BRIEF OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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In the Supreme Court

OF THE

United States

OCTOBER TERM, 1990

No. 90-97

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, Et Al., --
*Respondents.*On Petition for Writ of Certiorari to
the United States Court of Appeals
for the Seventh CircuitBRIEF OF THE FEDERATION OF
AMERICAN HEALTH SYSTEMS
AS AMICUS CURIAE IN SUPPORT OF THE
PETITION FOR A WRIT OF CERTIORARI

The Federation of American Health Systems ("FAHS") submits this brief, as *amicus curiae*, in support of the American Hospital Association's ("AHA") petition for a writ of certiorari, and urges this Court to review, and reverse, the Opinion and Judgment of the United States Court of Appeals for the Seventh Circuit entered in these proceedings on April 11, 1990.

FAHS files this brief with the consent of the parties herein, and their written consents are filed concurrently herewith.

INTEREST OF AMICUS CURIAE

Federation of American Health Systems ("FAHS") is an Internal Revenue Code Section 501(c)(6) organization which represents the interests of approximately 87 hospital management companies and approximately 258 independent investor-owned hospitals before the federal government. Together these companies presently own or operate 1,392 hospitals with a total of 168,475 beds. In addition, the management companies manage under contract an additional 329 not-for-profit hospitals in the United States and Puerto Rico, with an additional 36,836 beds. FAHS members own, operate and/or manage hospitals in all fifty states, the District of Columbia and Puerto Rico. In many cases the members operate hospitals in rural areas or small cities and towns, where they are the only provider of acute care services. FAHS has a direct interest in these proceedings because all of the investor-owned acute care hospitals, and many of the managed acute care hospitals, are subject to the National Labor Relations Board's ("Board") new health care bargaining unit Rule ("Rule"), 29 C.F.R. § 130.30. The Rule could affect each FAHS member who becomes a party to the representation procedures of the National Labor Relations Act, 29 U.S.C. § 151, *et seq.* (the "Act").

INTRODUCTION AND SUMMARY OF ARGUMENT

FAHS is concerned that, if permitted to stand, the court of appeals' opinion upholding the Rule, *inter alia*, eliminates an acute care hospital employer's right to be heard at a meaningful time and in a meaningful manner in bargaining unit determination proceedings. The Board's Rule establishing fixed appropriate bargaining units for acute care hospitals not only constitutes a breach of the Board's duty to investigate representational issues

on a case-by-case basis, it also denies procedural due process to the employer.

FAHS concurs with petitioner AHA's position before the lower courts and this Court regarding the extent of the Board's rulemaking authority in proceedings under Section 9 of the Act, 29 U.S.C. § 159 ("Section 9") and the Board's failure properly to consider the unduly proliferative effects of the Rule's eight units. FAHS further respectfully submits that the Board and the court of appeals failed to give due consideration to the existing diversity and to the continuing changes that are occurring within the health care industry. If permitted to stand, the decision of the court of appeals to uphold the Rule will needlessly and improperly impinge upon a hospital's ability to adapt and change its operating structure and work force in response to the realities of the changing health care economic environment—to the detriment of the health care industry as well as the public at large, which relies upon the ready availability of high quality and uninterrupted health care services.

The record of the Board hearings conducted before adoption of the Rule is replete with evidence regarding the diversity—size, location, patient population, workforce structures, reimbursement structures and mission—in the health care industry. The Board, however, ignored this evidence, as well as its own past findings regarding the diversity of the industry, and based its unit determinations instead upon supposed historical and uniform divisions and distinctions between employee groups. In so doing, it disregarded the substantial evidence of increasing integration and overlapping of work functions, new and developing multi-disciplinary team approaches, and restructurings of traditional operational and managerial systems. Even assuming *arguendo* that the current state of diversity is such that the Board's conclusions could have some present rational underpinning, further diversification of health care delivery systems, and the resulting changes on the structure and utilization of the workforce, must and will continue into the future as health care employers search for new and innovative methods for dealing with the critical national problems of rising health care costs, an increasingly acutely ill patient population and reduced or changing governmental and third party reimbursement structures.

The district court below correctly noted that the Board's Rule mandates automatic fragmentation of the bargaining units in a diverse and changing health care industry, stating:

In sum, we find that Section 9(b) of the NLRA does not entirely foreclose the Board from promulgating rules with respect to appropriate collective bargaining units. Congress, however, enunciated a specific concern for the vulnerability of the health care industry to labor unrest. In light of this vulnerability Congress admonished the Board to give due consideration to undue proliferation of bargaining units in this industry. A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. *In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.*

(Petitioner's App., pp. 41a-42a.) (Emphasis supplied.) The court of appeals, although it reversed the district court's grant of an injunction against enforcement of the Rule, also conceded that the Rule does not account for distinctions in a changing health care industry stating:

The lumping together of all acute-care hospitals into one category for purposes of prescribing proper bargaining units does of course overlook a great deal of relevant diversity. . . . A rule makes one or a few of a mass of particulars legally decisive, ignoring the rest.

(Petitioner's App., pp. 14a-15a.)

Indeed, even the Board itself had previously acknowledged that "[the] diverse nature of today's health care industry . . . precludes any generalization as to the appropriateness of any particular bargaining unit." *St. Francis Hospital*, 271 NLRB 948, 953 n.39 (1984). Yet, only five years after making that observation the Board cavalierly discounted this diversity as anomalous and insignificant, and instead found the health care industry sufficiently uniform and identical with respect to the factors central to determining appropriate units to justify establishing fixed units. NPR I, 52 Fed. Reg. at 25145.

Based on this "finding," the Board established eight (8) health care bargaining units, which may be challenged by a hospital only

if it can show "extraordinary circumstances." As defined by the Board, however, the extraordinary circumstances exception is an artifice, and anything but an "open ended exception" as the court of appeals erroneously characterized it. It provides no meaningful opportunity for a hospital to present evidence regarding the factors that have always been and, in fact, continue to be, central to appropriate unit determinations. Thus, it denies the acute care hospital the opportunity to show that, despite the presumed similarity among institutions, the circumstances in its particular case warrant a different result. The Act and the due process guarantees of the Fifth Amendment to the Constitution of the United States do not permit this result, and FAHS urges this Court to grant review and to reaffirm that acute care hospitals are entitled to the same basic procedural due process rights as are accorded other employers.

ARGUMENT

The Rule raises a crucial constitutional issue regarding the extent to which the Board may deprive an acute care hospital of due process in its representation proceedings. The court of appeals decided the narrow issue that the Board had authority to bring the unit determination process in the health care industry under the aegis of an administrative rule. However, the question of whether the Rule, as the Board has announced that it will apply it, affords hospitals the procedural due process required to pass constitutional muster was neither raised nor addressed. FAHS demonstrates herein that, inasmuch as the Board's unit determinations can and do substantially affect an acute care hospital's liberty and property interests, the Rule upheld below does not comport with this Court's longstanding concern for the protection of due process rights, and the court of appeals opinion sustaining the Rule should be reviewed and, ultimately, reversed. See, e.g., *Goldberg v. Kelly*, 397 U.S. 254, 25 L.Ed.2d 287 (1970); *Den v. The Hoboken Land and Improvement Co.*, 59 U.S. 277 (1855).

THE BOARD'S RULE DENIES PROCEDURAL DUE PROCESS TO HOSPITALS

The Rule's mandate of eight units without provision for an evidentiary hearing on the appropriateness of those units in the context of an individual hospital's circumstances substantially affects the investment-backed expectations of investor-owned hospitals, the right and freedom of all private hospitals to pursue a common occupation or calling, and the right of all hospitals to contract—all constitutionally protected property and/or liberty interests. See *Ruchelshaus v. Monsanto*, 467 U.S. 986, 1012 (1984); *Board of Regents v. Roth*, 408 U.S. 564, 572 (1972); *Hardware Dealers' Mutual Fire Ins. v. Glidden Co.*, 284 U.S. 151, 157 (1931). The Due Process Clause of the Fifth Amendment to the Constitution of the United States ("Due Process Clause") restricts both the powers of all three branches of the federal government and those of any administrative agencies created to implement and enforce their laws, orders or decisions, when the exercise of such powers may result in a denial of any person's life, liberty or property. See e.g., *Den v. The Hoboken Land and Improvement Company*, 59 U.S. 272 (1855); *Richardson v. Perales*, 402 U.S. 389, 1426-1427 (1971).

"Due process" is not a concept that can be categorically stated or mechanically applied. Rather, the requirements of due process vary with the nature of any given situation. *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Hannah v. Larche*, 363 U.S. 420 (1960). Relevant to a determination of the extent and nature of the requirements of due process in a particular case are: (1) the nature of the alleged right involved; (2) the length of the possible deprivation of the interest involved; (3) the risk of an erroneous deprivation; (4) the nature of the proceeding; and (5) the government's interest involved. *Mathews v. Eldridge, supra*. The fundamental requirement of due process remains the right to be heard "at a meaningful time and in a meaningful manner." *Mathews, supra*, at 333; *Armstrong v. Manzo*, 380 U.S. 545 (1965).

When the aforementioned factors are considered, it is clear that the Board's Rule does not afford that right, and therefore does not afford the due process required in such proceedings.

A. The Act's Mandatory Collective Bargaining Provisions Substantially Affect A Hospital's Liberty And Property Interests

In the absence of a certified collective bargaining representative, an employer is free to contract with employees individually or on whatever broader base it chooses.¹ However, once a bargaining representative is certified for a particular group of the employer's employees, the Act greatly restricts those rights and freedoms, and the employer loses the ability to contract with those employees individually and according to its needs or circumstances. Instead, a mandatory bargaining relationship is artificially imposed by statute upon the employer, and it must bargain for a contract covering the certified unit. The employer can no longer lawfully make changes regarding "rates of pay, rules and working conditions"² within that unit unless and until agreement or impasse is reached with the bargaining representative.³ These statutorily imposed obligations and restrictions are enforceable against the employer through both administrative and judicial process. 29 U.S.C. § 160. Thus, certification of a collective bargaining representative through the representation procedures

¹ Subject only to the general law of contracts (and various specific wage and hour and antidiscrimination laws), a hospital is normally free to alter the terms and conditions of its contracts with employees or groups of employees if it deems changes to be necessary. For instance, if circumstances warrant or dictate a change, the hospital is free to reassign, recombine or otherwise alter the duties of its employees; alter schedules or methods of scheduling; alter the pay or pay structure; contract with another entity for the provision of services formerly provided by its own employees; alter the size and makeup of its workforce; etc.

² A myriad of items are covered by the phrase "rates of pay, rules and working conditions," including scheduling, workforce size and makeup, job functions, and utilization of employees and equipment, to name but a few, and a restriction on any one of these areas has a substantial impact upon a hospital's exercise of its liberty and property rights in the operation of its business.

³ As a practical matter, the statutory bargaining obligation affords the group's representative the ability to delay, inhibit or prevent an employer's attempt to make timely, appropriate changes in the manner by which it conducts its business activities, and/or to allocate its resources in the manner it feels is most productive and beneficial, without regard for the reasonableness and/or necessity of such actions.

of Section 9 substantially restricts an employer's freedom to employ capital effectively, to assign and reassign work, or otherwise to change the manner by which it conducts its business.

The Board's unit determination lies at the very heart of this administrative process whereby an employer may be deprived of, or greatly restricted in the exercise of, substantial property and liberty interests. It is that determination which establishes and defines the group with which the employer must bargain as a distinct entity. Where there are two or more separately represented employee groups, the restrictions are compounded. While these are restrictions that Congress may validly impose as a general matter pursuant to its broad commerce powers, if the grouping(s) resulting from the Board's unit determination bear(s) no reasonable relationship to the employer's structure and operations, then the resulting adverse effects of the restrictions upon the employer's ability effectively to employ capital and operate its business are further and improperly exacerbated.

B. The Effects Of Unit Determinations Are Long Term And Potentially Permanent

The restrictions placed on an employer's rights and interests by virtue of the representation process are substantial. A unit certification can have a long term impact, since once a bargaining representative is certified for a particular unit it can potentially retain that status for as long as the employer remains in business. The employer has no unilateral ability to alter or terminate that status short of going out of business in whole or in part, or subcontracting out the work performed by bargaining unit employees.⁴ Despite this fact, the Board expressly crafted the Rule in a manner designed to prevent the employer from challenging or obtaining any review of its application to the employer. Accordingly, the adverse impact of an erroneous administrative unit determination may, as a practical matter, be permanent.

⁴ Even in these circumstances the employer has a duty to bargain, either over the decision and its effects or over the effects alone, depending upon the circumstances. *First National Maintenance Corp. v. NLRB*, 452 U.S. 666 (1981).

C. The Rule Denies An Employer Any Meaningful Opportunity To Be Heard In Administrative Proceedings That Affect Its Liberty And Property Rights And Interests

The appropriate unit is determined through an administrative hearing to which the employer and the petitioner seeking to represent a group of the employer's employees are parties. Over the decades since the Act's enactment, the Board has identified and refined a number of factors that it considers relevant and central to determining an appropriate unit. These factors concern whether or not the work-related conditions and interests of various employees are such that those employees can effectively bargain as a group over wages, hours and other conditions of employment. Not surprisingly, consideration of these factors as they exist in the case of a particular employer typically leads to units that reflect the divisions of the workforce based upon its operating structure, since those divisions tend also to mark a division of the relevant interests of groups of employees.

Heretofore, each party has always been afforded the opportunity to appear at the hearing and present evidence regarding the relevant factors. Thus, over the years, the Board has been able to exercise its discretion and judgment after consideration of a complete evidentiary record. As a practical matter, because most of the relevant factors concern the employer's operations, policies, procedures, benefits, wage scales and structures, supervisory structures, etc., the employer's participation has always been an essential part of this process, particularly since the employer has exclusive access to much of the relevant evidence.

In developing its Rule, the Board never once suggested that it had concluded that the unit determination factors it considers relevant in every other industry (including the entire health care industry before promulgation of the Rule) are no longer relevant to acute care hospitals. To the contrary, the Board examined those very factors, but concluded that they exist with sufficient uniformity throughout the industry to warrant its inflexible Rule.⁵

⁵ The Board's broad statement that its experience in handling hundreds of hospital bargaining unit cases over 13 years demonstrated that all such facilities were "remarkably uniform" and "virtually identical" is interesting, to say the least, when examined both in light of its past statement, noted earlier, that "[the] diverse nature of today's health

From this conclusion the Board created a Rule establishing fixed units, and through this Rule the Board proposes for the first time to deprive an employer of a meaningful opportunity to present evidence in the administrative proceedings regarding any of the factors relevant to the appropriate unit determination as they exist at the employer at the time when a petition for representation is actually filed.

Putting aside the facts that the Board flatly ignored substantial uncontradicted evidence both of an existing and of a developing diversity among hospitals, and that only a few years earlier the Board declared that its entire prior experience established that no generalizations could be made regarding appropriate units in the health care industry, it is nevertheless beyond dispute that the Board's Rule is premised upon very generalized findings. These findings are, in turn, based upon an amalgamation of evidence that does not directly relate, in toto, to any specific employer, and certainly does not directly relate to every employer. The typical hospital constructed by the Board from its hearings is much like the "average American family": it is a fictional model that bears no necessary relationship to any real situation. However, the Board would now apply its Rule to overlay fixed units onto a specific employer's operational and work force structures irrespective of, and, in fact, with express disregard for, whether the factors upon which the units were based are actually present in a manner resembling that which the Board has declared them to be.

While the court of appeals is correct that in most cases a rule "makes one or a few of a mass of particulars legally decisive, ignoring the rest" (Petitioner's App., pp. 15a), the instant Rule does not fit that description in any appropriate sense. Instead, it makes every otherwise relevant particular legally irrelevant by ignoring the entire mass. The only "particulars" that are decisive under the Rule are (1) that the employer is an acute care hospital and (2) that it has at least six of the types of employees that are included in the unit in question.

care industry . . . precludes any generalization as to the appropriateness of any particular bargaining unit" (*St. Francis Hospital*, 271 NLRB 948, 953 n. 39 (1984)), and this Court's more general observation that "wide variations [and] complexities of modern industrial organization [preclude] the use of inflexible rules as the test of an appropriate unit." *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

Because the Rule effectively prohibits the introduction and consideration of evidence regarding any of the otherwise relevant factors, it effectively reduces the employer's status and role in the proceedings to that of a mere observer. It does so even though determinations having a potentially significant impact upon the employer's constitutionally protected property and liberty interests are made in those proceedings. The opportunity to be heard in a meaningful manner and at a meaningful time requires more.

II

BY DENYING AN OPPORTUNITY TO BE HEARD THE RULE INCREASES THE POTENTIAL FOR THE ERRONEOUS DEPRIVATION OF A HOSPITAL'S LIBERTY AND PROPERTY INTERESTS

Recognizing the inflexibility of the Rule and its impact upon a changing health care industry, the district court stated:

An adjudicated rule may be adapted to factual distinctions, whereas the Board's rule which predetermines units, necessarily ignores differences which, although the Board refers to them as subtle, may be the key to labor peace.

(Petitioner's App., p. 39a.) (Bracketed material supplied.) The inflexibility of the Rule, as opposed to case-by-case examinations or even rebuttable presumptions, can only substantially increase the likelihood that an erroneous decision will be reached, with the resulting unwarranted deprivation of the employer's property and/or liberty rights and interests. Indeed, since the Board did not find that the factors it has always considered relevant and central to the appropriate unit determination are no longer so in the case of acute care hospitals, the denial of the opportunity for an employer to show that the evidence regarding those factors varies in its case from that which formed the basis for the units contained in the Rule not only increases the likelihood of an erroneous decision in the case where factual differences exist, but practically assures an erroneous decision in the case where those differences are both substantial and widespread.

III

THE RULE IS IRRATIONAL AND DOES NOT SERVE ANY LEGITIMATE GOVERNMENTAL INTEREST

The Board's creation of an absolute Rule, in complete disregard for substantial and uncontradicted evidence establishing that hospitals are in the process of undergoing fundamental change, and that there is a substantial present and growing diversity among acute care hospital employers, is irrational. Although the Board cites several interests that it contends justify or support the Rule, in fact, the Rule serves or furthers no legitimate purpose or interest that warrants a denial of due process. *See Jackson Water Works, Inc. v. Public Utilities Comm.*, 793 F.2d 1090, 1097 (9th Cir. 1986). The interests cited by the Board include that of assuring the fullest freedom by employees to bargain collectively, that of creating certainty in the application of the Rule, and that of avoiding excessive or duplicative litigation.

Congress declared the purpose of Section 9 to be to assure employees the freedom to bargain collectively, and the unit determination was established as a central part of the process established by that Section. Specifically, Section 9(b) provides that in order "to assure to employees the fullest freedom in exercising the rights guaranteed by this Act," the Board is to determine the "unit appropriate for the purposes of collective bargaining." 29 U.S.C. § 159(b). As described above, such a unit is determined in proceedings under Section 9(c), 29 U.S.C. § 159(c), based upon the factors that the Board has identified and determined to be relevant over the course of several decades.

The Rule irrebuttably presumes that the relevant factors supporting a particular unit always exist in a certain fashion in acute care hospitals. If one accepts the proposition that the Rule's units are appropriate based upon the "facts" found by the Board in the rulemaking process (and FAHS does not concede that they are), then as long as the relevant factors also happen to exist in a given case as the Rule presumes they do, the resulting units would be appropriate. However, the mechanical application of the Rule to a setting where the factors simply do not exist in that fashion, or anything closely resembling that fashion, does *not* result in an appropriate unit. Since Congress has declared that an appropriate unit furthers the underlying statutory purpose, it would seem to follow that the Rule will likely frustrate rather than serve the

declared statutory goal and purpose of the Section 9 unit determination procedure since it will, in many cases, establish inappropriate units under the Board's own established standards.

In promulgating the Rule, the Board also stated that it sought to take advantage of the "certainty" that such a rule would offer. NPR I, 52 Fed. Reg. at 25145. FAHS concedes that the certainty of the Rule may be convenient and advantageous to the Board, and, for that matter, to labor organizations as well. FAHS also agrees with the court of appeals' observation that a result of a rule "is a gain in certainty, predictability, celerity, and economy, and a loss in individualized justice." (Petitioner's App., p. 15a.) FAHS would vigorously disagree, however, with any suggestion that "the tradeoff is worthwhile" in this case. Neither certainty nor the advantages it offers to the Board and/or labor organizations can take precedence over the express purposes of Section 9 or constitutional due process requirements. This is particularly so where that certainty is obtained at the expense of an employer's property and liberty interests, and under circumstances that, as shown above, may actually frustrate the statutory purpose of assuring employees of the right to bargain collectively in an effective manner by establishing units that are inappropriate rather than appropriate for such purposes.

Lastly, the Board supports its Rule on the basis that it is more effective than rebuttable presumptions in resolving the Board's concern about duplicative litigation. Final Rule, 54 Fed. Reg. at 16338-39. Given the Board's horrendous record in making health care unit determinations, one can appreciate that the Board would like to put an end to the seemingly endless series of appellate decisions rejecting its health care unit determinations and criticizing it for failing to heed past judicial direction. One can also make a strong, if not overwhelming, case that, in light of the employers' historical success rate before the courts, the Board and not employers must bear responsibility for that history of litigation. Be that as it may, however, the simple fact is that the Rule will not reduce litigation. If anything, litigation will, in all likelihood, increase.

In recognition of the due process issues posed by the irrebuttable and fixed units, the Board created in the Rule a so-called "extraordinary circumstances" exception. While, as discussed below, this exception is really no exception at all, it is, nevertheless, the only possible vehicle under the Rule by which an acute

care hospital employer may even attempt to establish that it does not fit the Rule's procrustean bed. As a result, one can reasonably anticipate that employers will challenge the Board's application and interpretation of the extraordinary circumstances exception, through the judicial processes established in Section 10 of the Act, 29 U.S.C. § 160, in every case where they believe that their own specific circumstances warrant or require the finding that a different unit is appropriate.

Moreover, although avoiding excessive or duplicative litigation may be a legitimate interest or concern, it must be served consistent with notions of due process, and not by simply ignoring or dispensing with them. See *Hardware Dealer's Mutual Fire Ins. Co. v. Glidden Co.*, 284 U.S. 151, 158 (1931); *Crane v. Hahlo*, 258 U.S. 142, 147 (1922). If that were not the case, then due process would have little if any meaning, since the easiest and best way to reduce litigation is simply to deny to one of the parties the right to participate in the process. Therefore, even if the Rule would actually reduce litigation, the Board cannot use its concern over litigation to justify the Rule's denial of due process to employers.

In fact, not only does the Rule serve no legitimate governmental interest, but it runs afoul of specific statutory language limiting the role that the "extent of organization" plays in determining appropriate units. At the same time that it restricted the employer's ability to contest the application of the Rule to "extraordinary circumstances," the Board specifically provided in the Rule that "combination" units may be appropriate if requested by a labor organization. 29 C.F.R. § 103.30(a) (Petitioner's App. p. 44a.) The only logical and practical reason for a labor organization to request a broader combination unit would be the extent of its organizing efforts (i.e., that, based upon its organizational efforts as of the time it files the petition, it believes it has the votes needed to prevail in an election in a broader combination unit). Since the Board has stated that variations in any or even all of the relevant circumstances at a specific facility from those it has found to exist throughout the industry will not be considered in unit determination proceedings, there is no basis left upon which the Board could find a combination unit appropriate, apart from the simple fact that the labor organization has requested it. Such a finding would be in direct disregard of Section 9(c)(5), which provides that the extent of organization cannot be controlling in

determining appropriate bargaining units. 29 U.S.C. § 159(c)(5).⁶

Thus, although the Board has articulated several interests which it claims are served by its Rule, an examination of the Rule and its workings clearly reveals that it serves none of them. As a result, the asserted interests do not justify the denial of the due process rights of acute care hospital employers.

IV

THE RULE'S "EXTRAORDINARY CIRCUMSTANCES" EXCEPTION IS A SHAM AND DOES NOT SATISFY DUE PROCESS REQUIREMENTS

As noted above, recognizing the due process issues raised by the Rule, the Board tacked on the "extraordinary circumstances" exception as a supposed cure-all. In presenting the exception to the court of appeals, the Board recited the following self-serving statements included in its comments accompanying the final rule:

Other situations may occur in which a party may contend that the number of employees in the petitioned-for unit, or other circumstances may require deviation from strict application of the rule. Thus, the 'extraordinary circumstances' exception remains available . . . for any party who wishes to argue for any reason that the rule should not be applicable to its facility.

(Board's Brief to the court of appeals, pp. 26-27.)

The Board also used the "extraordinary circumstance" exception to attack the district court's characterization of the Rule as one that "mandates an absolute number of appropriate units and mandates a particular division of the work force, . . . in the health care field where employees' work environment vary widely." To convince the court of appeals otherwise, the Board stated that:

. . . if there are material differences in working conditions at a particular acute care hospital which would differentiate it from the typical acute care hospital encompassed by the Rule, the atypical hospital may be able to make a showing of

⁶ FAHS also notes that the establishment of different rules of decision and standards to be applied to employers and labor organizations would appear to violate at least the spirit of Section 9(c)(2), 29 U.S.C. § 159(c)(2).

"extraordinary circumstances" which would exempt it from the coverage of the Rule.

(Board's Brief to the court of Appeals, p. 42.)

These descriptions of the "extraordinary circumstances" exception, standing alone, sound fair enough, and they apparently convinced the court of appeals, which characterized it as an "open ended exception for cases in which a party can demonstrate exceptional circumstances." (Petitioner's App., pp. 15a-16a.) The Board no doubt would also like this Court to believe that the exception actually satisfies all possible due process requirements. If the Board intended the exception to apply in the manner in which the term "extraordinary" is defined and commonly understood, or even in the manner it described to the courts below, then perhaps it might comport with minimal due process requirements. The Rule would then be more in the nature of a rebuttable presumption and in line with the decisional or adjudicatory rules that the Board has developed in the past for use in unit determinations. It would also then be more in keeping with the requirement that the Board make such determinations on a case-by-case basis.

Unfortunately, however, the Board has stated explicitly that the units established by the Rule are not rebuttable presumptions, and has gone to great lengths to define the "extraordinary circumstances" exception in such a manner so as to preclude its application in virtually every conceivable circumstance. When the Board first announced the "extraordinary circumstances" exception, it explained at length its interpretation thereof. That explanation, set forth below, demonstrates that, as the Board intends to apply it, the exception is no exception at all:

[T]he Board wishes to emphasize that while the rule does not . . . conclusively establish invariable parameters of bargaining units in the industry, our intent is to construe the extraordinary circumstances exception narrowly, so that it does not provide an excuse, opportunity, or "loophole" for redundant or unnecessary litigation and the concomitant delay that would ensue. The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between the acute care hospitals, some of which are enumerated below, are matters

which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions. *The Board deems such variations to be ordinary, and hence by definition not extraordinary, even in situations in which such variations may be highly unusual.*

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross training of employees; (3) the impact of nation-wide hospital "chains;" (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), *the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above, alone or in combination, constitutes an "extraordinary circumstances" justifying an exception from the rule.*

The Board is well aware that facilities will, and do, differ in some respects; however, as we have observed in the NPR (52 FR 25144), it is the Board's considered judgment, after issuing healthcare decisions by adjudication for more than 13 years, that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units. Moreover, to the extent that the rulemaking hearings demonstrated that at least in some respects acute care hospitals do vary, the Board has made a judgment that, in this area of establishing appropriate units, "[d]etailed analysis of all the facts of the particular case are just not that

enlightening" and that the policies of the Act would better be effectuated by the establishment of appropriate units in the enumerated segments of this industry by exercise of the Board's section 6 rulemaking authority.

To satisfy the requirements of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding" as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust or an abuse of discretion for the Board to apply the rules to the facility involved.

[Footnotes omitted.]

NPR II, 53 Fed. Reg. at 33932-33 (emphasis supplied). The Board also made it clear that the variations described are merely illustrative of, and not exclusive or exhaustive of, the types of variations that it will not consider. 53 Fed. Reg. at 33932, n.31.

In announcing the final Rule, at the same time that it made the earlier quoted statement suggesting that the exception might actually have some meaningful application, the Board expressly reaffirmed its original interpretation set forth above. Final Rule, 54 Fed. Reg. at 16345.

The inclusion of the "extraordinary circumstances" exception in the Rule does no more than pay lip service to a hospital's due process rights, since the Board has excluded from that exception evidence relating to virtually every factor that has ever been considered relevant to unit determinations. Indeed, the Board has, as a practical matter, even foreclosed a hospital from effectively invoking the "extraordinary circumstances" exception where it has made sweeping, innovative changes both in its operations and in the structure, utilization and makeup of its workforce, which changes vary substantially from any of the circumstances found to be uniformly present by the Board in the rulemaking process. The Board has unequivocally stated that any such evidence would be considered "ordinary" and "by definition not extraordinary, *even in situations in which such variations may be highly unusual*", or where a number of such variations exist "*in combination*." (NPR II, 53 Fed. Reg. at 33932) (emphasis supplied). Thus, the Board

has held out the "extraordinary circumstances" exception to "satisfy" due process, only to take it back through a not-so-subtle exercise of lexicological sleight of hand.

Finally, although the Board has attempted through general statements to show the significance of its "extraordinary circumstances" exception, it is both notable and revealing that the Board, was, and apparently is, unable to offer a single example (other than the "5 employees or less" exception expressly set forth in the Rule) of what might actually constitute an "extraordinary circumstance." This is, of course, because the Board has never actually intended for there to be any "extraordinary circumstance" and, based upon its own definition of what is not "extraordinary," it, like everyone else, is unable to conceive of one.

Since the Rule has a substantial impact upon a hospital's constitutionally protected interests, and, despite the "extraordinary circumstances" exception, effectively precludes any opportunity for a hospital to be heard at a meaningful time (i.e., at the time the Rule is being applied to that hospital), it denies the acute care hospital employer procedural due process in violation of the Due Process Clause, and is, therefore, invalid.⁷ See

⁷ As noted earlier, at the same time that it created the narrowly construed "extraordinary circumstances" exception to be applied to the acute care hospital employer, the Board provided an option to labor organizations to request and obtain units other than those established by the Rule. The Board mandated that the Rule's eight units are the "only" appropriate units, "except that, if sought by labor organizations, various combinations of units may also be appropriate . . ." § 103.30 of the Final Rule (Petitioner's App. p. 44a) (emphasis supplied). This exception for labor organizations also raises equal protection issues. Under the equal protection standard applicable to regulation of economic and commercial matters, challenged distinctions will only be sustained if the governmental agency could have reasonably concluded that it would promote a legitimate government purpose. *Exxon Corp v. Eagerton*, 462 U.S. 176 (1983). In Section 9 proceedings, both the employer and the labor organization are similarly situated—each is a party to the representation hearing, and the collective bargaining rights, obligations and restrictions of each will be determined through that process. However, the Board has determined that only in extraordinary circumstances (which it very narrowly defined) can a hospital challenge the appropriateness of the eight bargaining units in its facilities, while, in contrast, a

Hardware Dealer's Mutual Fire Ins. Co. v. Glidden, 284 U.S. 151, 158 (1931); *Crane v. Hahlo*, 258 U.S. 142, 147 (1922).

CONCLUSION

For the reasons advanced by the AHA, and for the reasons set forth above, FAHS respectfully requests that the Court grant AHA's petition for a writ of certiorari and that it reverse the Seventh Circuit Court of Appeal's denial of a permanent injunction.

Respectfully submitted

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labor organization is granted a broad exception to seek a bargaining unit other than one of the eight bargaining units provided for in the Rule.

Both labor organizations and hospitals had the opportunity to present their respective views on the appropriateness of the proposed rule. After these hearings the Board then determined that the *only* appropriate units would be the eight proposed units. The Board's grant of an exemption for labor organizations to in essence "relitigate" or "reopen" this issue, while denying that same opportunity to the employer, is not based upon any legitimate purpose. In support of this exception, the Board pointed out that since it has already determined that the dictated number of units do not proliferate, a petition for a combination of units would be appropriate, since it would proliferate even less. NPR I, 52 Fed. Reg. at 25145. It is noteworthy that the units that employers typically seek in unit determination proceedings are what would be "combination" units under the Rule (i.e., "all professionals" "service and maintenance", "service, maintenance and technical", etc.). There is simply no legitimate basis, either in the record or in logic, for granting this exemption to a labor organization but not to a hospital employer. A combination unit proposed by the employer would be every bit as nonproliferative as it would be if it were proposed by the labor organization.

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No. 90-97

Supreme Court, U.S.
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CLERK

In The
Supreme Court of the United States
October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

Petition for a Writ of Certiorari To The United States
Court of Appeals for the Seventh Circuit

**BRIEF OF ST. FRANCIS HOSPITAL, INC. OF
MEMPHIS, TENNESSEE AS AMICUS CURIAE
IN SUPPORT OF PETITIONER, AMERICAN HOSPITAL ASSOCIATION.**

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IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1990

No. 90-97

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF
APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF ST. FRANCIS HOSPITAL, INC. OF
MEMPHIS, TENNESSEE AS AMICUS CURIAE
IN SUPPORT OF PETITIONER AMERICAN
HOSPITAL ASSOCIATION

INTEREST OF THE AMICUS CURIAE¹

St. Francis Hospital, Inc. of
Memphis, Tennessee (hereinafter St. Francis)

¹This brief of Amicus Curiae is filed with the written consent of the parties. The letters giving consent have been separately filed with the Court.

is an acute-care hospital and, therefore, is affected by the Rule promulgated by the National Labor Relations Board regarding appropriate bargaining units in the health-care industry. St. Francis, having been exposed to organizing efforts by groups of its employees and involved in years of related litigation (see St. Francis "I", 265 N.L.R.B. 1025 (1982), and St. Francis "II", 271 N.L.R.B. 948 (1984)), is acutely aware of the need to consider each request for a collective-bargaining unit on the facts of the particular case and the need to avoid undue proliferation of bargaining units in the health-care industry.

St. Francis is keenly interested in the outcome of this matter. If the Board's rule prevails, creating a virtually irrebuttable presumption that eight units are appropriate, St. Francis could be subject to organizing in the same maintenance unit found inappropriate in the past. St. Francis would have to challenge the appropriateness of the unit again,

inevitably resulting in further litigation. St. Francis, therefore, submits this Brief in Support of the pending Petition for Writ of Certiorari.

STATEMENT OF THE CASE

This cases arises out of a suit by the American Hospital Association (hereinafter, AHA) to permanently enjoin the National Labor Relations Board (hereinafter, NLRB or the Board) from enforcing its newly promulgated Rule, 29 C.F.R. § 103, pertaining to bargaining units in the health-care industry (hereinafter, the Rule). Promulgated under Section 6 of the National Labor Relations Act (the NLRA or the Act), 29 U.S.C. § 156, the Rule establishes eight units, and only eight units, as presumptively valid for collective-bargaining purposes in the acute-care hospital industry. In promulgating the Rule, the Board has disallowed parties from raising as reasons

to rebut the presumption virtually all of the factors raised by parties for the past 13 years to dispute unit appropriateness.

AHA asked the district court below to declare the Rule invalid, based on three alternative grounds: (1) the Rule contravenes Section 9(b) of the Act, 29 U.S.C. § 159(b), which provides that bargaining-unit determinations must be made "in each case," (2) the Rule contravenes the 1974 health-care amendments, which mandate that the Board avoid undue proliferation of bargaining units in the health-care industry, and (3) the Rule is arbitrary and capricious and is not supported by substantial evidence. American Hospital Association v. NLRB, et al., 718 F. Supp. 704, 705 (N.D. Ill. 1989). The district court found the Rule invalid and granted AHA's request for injunctive relief. Id. at

716. The court stated that the "in each case" language required the Board to make unit determinations tailored to each individual case. Id. at 712-13. The court found that this limitation did not foreclose the Board from undertaking rulemaking in fulfilling its Section 9(b) charge, but the court left for another day the question of limitations to the Board's rulemaking function under Section 9(b). The court further found that, in light of the congressional admonition to give consideration to undue proliferation of bargaining units in the health-care industry, a rule that designates such an absolute number of appropriate units and mandates a particular division of the workforce is not responsive to Congress' express concern. Id. at 716. The court found it unnecessary to reach AHA's claim that the Rule was arbitrary, capricious, and not supported by the evidence. Id.

The NLRB appealed the district court's decision, and, in American Hospital

Association v. NLRB, et al., 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed, finding that Section 9(b) does not require the Board to make bargaining-unit determinations on a case-by-case basis, and that, to the extent that unit determinations must be made on a case-by-case basis, the Board's resort to formal rulemaking satisfied this requirement. The Seventh Circuit further found that the Rule did not violate the congressional admonition and that the Rule as promulgated by the Board was not arbitrary or capricious. Id. at 659-60. Thereafter, AHA petitioned this Court for a Writ of Certiorari.

SUMMARY OF THE ARGUMENT

Although the Act does not entirely foreclose the Board from promulgating rules regarding the determination of appropriate collective-bargaining units, a rule, such as the present one, which does not give consideration to the congressional mandate that collective bargaining units be

determined upon the facts of each individual case, is improper. The Rule is inconsistent with the language of the NLRA that unit determination be undertaken on an individual case-by-case basis.

The pertinent legislative history illustrates that, in 1934-35, all involved in the legislative process of what would ultimately become Section 9(b) were well aware that Congress had chosen the Board to make bargaining-unit determinations; no modification of the original Section 9(b) language was necessary to clarify that point. Therefore, the "in each case" language, which was added to the final version of Section 9(b) for "clarification," was added to the Section for some reason other than choosing the Board as the unit determiner. The real reason, according to the plain meaning of the "in each case" phrase, was to instruct the Board to make bargaining-unit determinations based upon the facts of each individual case.

In the past, the Board and the courts have all concluded that Section 9(b) (and other, similar statutes) requires the Board to make unit determinations on a case-by-case basis and further have held that many of the eight units designated by the new Rule are, in fact, sometimes inappropriate, depending on the circumstances of the case. Therefore, the Board, by exercising (out of futility) its rulemaking authority, has substituted a quick-fix resolution of bargaining-unit disputes for the required case-by-case determinations that allow each party to show which units are appropriate in any facility. Only in individual proceedings can the Board properly weigh the competing claims for particular units.

Further, the Rule is improper in light of Congress' enunciated concern that the health-care industry is vulnerable to labor unrest and that, therefore, the Board should give due consideration to preventing proliferation of bargaining units in this industry. A health-care rule mandating

eight units fails to take into account Congress' express concern.

ARGUMENT

I.

CONTRARY TO THE DECISION OF THE COURT OF APPEALS, THE BOARD'S NEW EIGHT-UNITS RULE VIOLATES THE STATUTORY MANDATE CONTAINED IN SECTION 9(b) OF THE NATIONAL LABOR RELATIONS ACT THAT COLLECTIVE BARGAINING UNITS ARE TO BE DETERMINED FROM THE FACTS IN EACH CASE

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), provides the following:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof:...

The language of the statute appears to be unambiguous: The Board is to determine the appropriateness of bargaining units based upon the facts of each individual case.

While Section 6 of the Act allows the Board to promulgate rules and regulations as it deems necessary to effectuate the policies of the Act, 29 U.S.C. § 156, St. Francis, in agreement with the Petitioner (see Petition for Certiorari, at 13), submits that Section 9(b) is a limitation on the Board's ability to promulgate a Rule relating to determining appropriate bargaining units. Read together, the two sections provide that the Board may promulgate rules and regulations regarding determination of appropriate bargaining units so long as such rules allow for unit determinations to be made on a case-by-case basis.

The Board exceeded its rulemaking authority under Section 6 in promulgating a Rule that eight, and only eight, units shall be appropriate for all acute-care

hospitals.² Such a rule does not allow for unit determinations to be made on the required case-by-case basis.

Although the Board did provide that it would not apply the rule in "extraordinary circumstances," it emphasized that such extraordinary circumstances would be extremely rare. The Board listed a number of factors that it will not consider

²The Board's Rule provides that, "except in extraordinary circumstances," the following eight units "shall be appropriate units, and the only appropriate units" for all acute-care hospitals:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All other nonprofessional employees.

29 C.F.R. § 103.30, The National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-48 (1989).

to be such "extraordinary circumstances."³ These excluded factors are basically the same criteria the Board formerly used in making case-by-case bargaining-unit determinations. By eliminating these factors as bases for challenging unit appropriateness, the Board has effectively precluded any meaningful challenge to its eight-units rule, thereby subverting the

³These factors will not be considered by the Board as "extraordinary circumstances":

- (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of out-patient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals);
- (2) Increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multicompetent worker, increased use of "team" care, and cross-training of employees;
- (3) The impact of nation-wide hospital "chains";
- (4) Recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (continued)

statutory mandate that all unit determinations be based on a case-by-case analysis.

While the Board may not enlarge its authority beyond the scope intended by Congress, the Board may, where restrictive intention is not shown, adopt rules and regulations to carry out its myriad functions in a manner consistent with the fulfillment of the purposes of the Act. Department & Specialty Store Employees Union v. Brown, 284 F.2d 619, 627 (9th Cir. 1960). Here, however, restrictive intention is shown by Congress' inclusion of the "in each case" language in Section 9(b).

³ (continued)

- (5) The effects of various governmental and private cost-containment measures; and
- (6) Single institutions occupying more than one contiguous building.

Notice of Proposed Rulemaking, 53 Fed. Reg. 33,932 (1988).

A. The "in each case" Language Contained in Section 9(b) Requires the Board to Base Unit Determinations Based upon the Facts of Each Individual Case; it does not Relate to the Congressional Choice of Who Should Make Unit Determinations.

Section 9(b) provides that the Board shall decide "in each case" the unit appropriate for collective bargaining. 29 U.S.C. 159(b) (1973). However, as originally drafted, Section 9(b) did not contain the "in each case" language. The Bill as introduced by Senator Wagner provided as follows:

(b) The Board shall decide whether, in order to effectuate the policies of this Act, the unit appropriate for the purpose of collective bargaining shall be the employer unit, craft unit, plant unit, or other unit.

S. 1958, 74th Cong., 1st Sess. 9(b) (1935), reprinted in Legislative History of the National Labor Relations Act, 1935, Vol. I at 1295 (1985) (hereinafter Leg. Hist.).⁴

⁴Senator Wagner originally proposed the "Labor Disputes Act," S. 2926, 73d Cong., 2d Sess. 1 (1934), Leg. Hist., Vol. I at 1, predecessor to the National Labor Relations Act, during the 73d Congress. Therein, at Section 207(a), Senator Wagner provided that "[t]he Board shall decide

The "in each case" language did not appear in this statute until May 1, 1935, when Section 9(b) was revised to read as follows:

(b) The Board shall decide in each case whether, in order to effectuate the policies of this Act, the unit appropriate for the purpose of collective bargaining shall be the employer unit, craft unit, plant unit, or other unit.

S. Rep. No. 573, 74th Cong., 1st Sess. 12 (1935), Leg. Hist., Vol. II at 2291 (emphasis added).

In the present case, the court of appeals held that the "in each case" language was added to indicate that the Board, not the employees, employer, or Congress, was to determine the appropriate

4 (continued)

whether eligibility to participate in elections shall be determined on the basis of employer unit, craft unit, plant unit, or other appropriate grouping." S. 2926, 73d Cong., 2d Sess. 19 (1934), Leg. Hist., Vol I at 11. Thus, as early as 1934, Senator Wagner intended that the Board was to determine appropriate bargaining units. Although this Bill was never enacted, it served as a guide to the National Labor Relations Act introduced and passed the following year.

unit for collective bargaining. American Hospital Ass'n v. NLRB, 899 F.2d at 656. However, from its inception, the original language of Section 9(b) had indicated that it was to be the Board that would determine the appropriate bargaining unit. Both the version introduced in 1934 before the 73d Congress in the "Labor Disputes Act," and the original version introduced in 1935 before the 74th Congress, clearly indicated that unit determinations were to be made by the Board.

The fact that it was obvious to everyone who read the original language of the proposed statute that Congress had decided to empower the Board to make bargaining-unit determinations, is evidenced by the number of associations and other interest groups that wrote to and appeared before Congress to protest the congressional choice of the Board as the bargaining-unit determiner. Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 302, 736-56 (1935), Leg. Hist., Vol. II at 1688, 2122-42.

Many of these interest groups argued that the employees themselves, not the Board, should have the right to determine their own units. Typical is the comment of R.W. Ayres, Chairman of the Employee's Representation Committee with Northwestern Bell, who opposed the portion of the pre-"in each case" Section 9(b) allowing the Board to determine the appropriate unit for collective-bargaining purposes; rather, said Mr. Ayres, "the employees should have the right to set up their own units for collective bargaining without interference from any outside force." As a result, Mr. Ayres declared, "we object to Section 9(b) in its entirety." Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 737 (1935), Leg. Hist., Vol II at 2123.

As indicated by such comments, it was clear to everyone involved, from the original language of Section 9(b) (which lacked the "in each case" language) that Congress had decided to establish the Board,

not the employees or anyone else, to decide appropriate bargaining units. It strains logic to imagine that Congress would have thought it necessary to modify the original version of Section 9(b) so as to reflect a choice for the Board as the bargaining-unit determiner, as held by the Seventh Circuit, when all involved in the legislative process certainly understood the original language to already make that choice.

An examination of the testimony of Secretary of Labor Frances Perkins, who testified in 1935 before the Senate Education and Labor Committee, sheds further light on the true purpose of the "in each case" language. At the conclusion of her testimony (which consisted primarily of arguing why the Labor Board ought to be made a part of the Department of Labor), Secretary Perkins indicated that she had a "number of other small amendments" to make to the Act "for the sake of clarity" and for "clarification of the duties and powers of the Board." Hearings on S. 1958 before the

Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 66 (1935), Leg. Hist., Vol I at 1442 (emphasis added). One of these "small amendments" proposed was the inserting of the "in each case" language in Section 9(b). Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 69 (1935), Leg. Hist., Vol. I at 1445; Hearings on H.R. 6288 before the House Comm. on Labor, 74th Cong., 1st Sess. 284 (1935), Leg. Hist., Vol. II at 2758.

Secretary Perkins did not further expand on the reason for the language change. However, since those who had read the original Section 9(b) language already knew that that language chose the Board to make bargaining-unit determinations, there was certainly no need for "clarification" (Secretary Perkins' word) to make that point. Therefore, "clarification" must have referred to clarifying some other point.

In addition, Secretary Perkins' reference to "clarifying" the "duties and

powers of the Board" suggests the true purpose of Secretary Perkins' amendment. The use of the word "duties" suggests actions the Board would be required to take. The Seventh Circuit's interpretation of the "in each case" phrase is, therefore, incorrect, since Congress' act of choosing the Board over employees does not connote a "duty" of the Board itself. On the other hand, the obligation to make unit determinations in each individual case would certainly be considered a "duty" of the Board.

In spite of the various reasons offered by the Seventh Circuit to explain the "in each case" language, it can surely be said that one of the reasons was not that Congress wanted to clarify Section 9(b) so that everyone would understand that the Board was responsible for making the decision as to unit appropriateness. The original pre-enactment Section 9(b) language chose the Board; therefore, it was unnecessary to make any other changes in

Section 9(b) in order to clarify this choice. Since the "in each case" language logically does not relate to the congressional choice of who should make unit determinations, it must relate to some other purpose: how the Board was to make unit determinations.

A plain reading of the "in each case" phrase, and in light of Secretary Perkins' comments and the legislative history of Section 9(b) as a whole, indicates that the "in each case" language was inserted to clarify that it was the Board's duty to make unit determinations based upon the facts of each individual case.

Petitioner and St. Francis' position is further supported by the Committee Report that accompanied the House version of the Act. H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935), Leg. Hist., Vol. II at 2930. Therein, the House explained that it chose the Board to make bargaining unit determinations because such

determinations had to be made "in each individual case." Id. Stated the House Report:

Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit, employer unit, or other unit. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination.

Id. (emphasis added).

The Seventh Circuit did not give the "in each individual case" phrase its complete meaning when it said--referring to the House's explanation--"[a]ll this appears to mean is that unit determination is a task meet for the Board rather than for either the Congress or the employees themselves." American Hospital Ass'n v. NLRB, et al., 899 F.2d at 656. To adopt the Seventh Circuit's rationale would render the above emphasized portion of the House's explanation meaningless since the latter part of that

phrase states that the Board is to make unit determinations. The comment makes two points, (1) unit determinations are to be made on a case-by-case basis, and (2) the Board is to make such determinations. The Seventh Circuit acknowledges the latter point, but not the former. It is a general rule of statutory interpretation that a court should not construe a statute in a way that makes words or phrases meaningless, redundant, or superfluous. Zimmerman v. North American Signal Co., 704 F.2d 347, 353 (7th Cir. 1983). Instead, a court should interpret a statute in a light that gives full effect to the language of the statute. See Department & Specialty Store Employees Union v. Brown, 284 F.2d 619, 626 (9th Cir. 1960). The Seventh Circuit's rationale renders the House's statement that "[t]his matter is obviously one for determination in each individual case," meaningless.

B. The Court of Appeals' Holding that Section 9(b) Does Not Require Unit Determinations to be Made on a Case-by-Case Basis is Contrary to Years of Established Case Law.

For over fifty-five years, the Board and the courts have interpreted

Section 9(b) to mandate that bargaining units be determined on a case-by-case basis. See, e.g., NLRB v. Hearst Publications, Inc., 322 U.S. 111, 134 (1944); NLRB v. Esquire, Inc., 222 F.2d 253, 256 (7th Cir. 1955); Kalamazoo Paper Box Corp., 136 N.L.R.B. 134, 137 (1962). In St. Francis II, the Board reiterated its understanding of the case-by-case mandate contained in Section 9(b):

The analysis we set forth today establishes neither a minimum nor a maximum number of appropriate bargaining units, but rather permits the determination to be made on the facts of the particular facility involved. We believe that this approach comports with Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis.

271 N.L.R.B. 948, 951 n. 17 (1984).⁵

⁵Section 9(b) applies to unit determinations for all bargaining units, not just those in the health-care industry. The Board's longstanding practice has been to make unit determinations in each individual case, giving consideration to the unique facts of each situation. It is well recognized that a court may accord great weight to the longstanding interpretation placed upon a statute by the agency charged with its administration. NLRB v. Bell Aerospace Co., 416 U.S. 267, 274-75 (1974); Red Lion Broadcasting Co. v. FCC, 395 U.S. 367, 381 (1969).

Likewise, the Eighth Circuit has held that bargaining-unit determinations must be made based upon the facts in each case. NLRB v. May Department Stores Co., 146 F.2d 66, 68 (8th Cir. 1944). See also NLRB v. Metal Container Corp., 660 F.2d 1309, 1313 (8th Cir. 1981) (craft unit determinations are to be made on a case-by-case basis after weighing all of the relevant factors). The Sixth Circuit has held that "an appropriate unit is a question of fact to be determined by the Board upon the facts of each case." Metropolitan Life Insurance Co. v. NLRB, 330 F.2d 62, 65 (6th Cir. 1964), vacated on other grounds, 380 U.S. 525 (1965).

In Kalamazoo Paper Box Corp., 136 N.L.R.B. 134, 137 (1962), the Board stated that its obligation under the statute was to enforce the mandate of Congress that the unit appropriate for the purposes of collective bargaining should be decided in each case. In addition, the Board stated the following:

Because the scope of the unit is basic to and permeates the whole of the collective-bargaining relationship, each unit determination, in order to further effective expression of the statutory purposes, must have a direct relevancy to the circumstances within which collective bargaining is to take place. [citation omitted] For, if the unit determination fails to relate to the factual situation with which the parties must deal, efficient and stable collective bargaining is undermined rather than fostered.

To accord automatically to a subgroup of employees such as truck drivers, severance from a larger established and stable bargaining unit merely on the basis of the existence of the traditional job classification and a request for a separate unit encompassing such classification, does not, in our opinion, adequately discharge this basic and far-reaching responsibility placed upon the Board by Congress. A title or classification in common usage does not necessarily establish that separate special interests exist and are preponderant. This can be determined only by making an informed judgment based upon an analysis of the factual circumstances bearing upon the distinguishing factors present in each case.

Id. at 137-38.

C. Other Statutes Containing the "in each case" Language have been Interpreted to Require Individual, Case-by-Case Determinations.

Other statutes, such as the Postal Reorganization Act (hereinafter PRA), 39 U.S.C. §1202,⁶ that contain the "in each case" language have been interpreted to require the Board to determine the appropriateness of bargaining units in each individual case. In United States Postal Service, 208 N.L.R.B. 948, 952 (1974), the Board stated that "the congressional mandate to this Board in the comprehensive PRA Legislation was to determine 'in each case the unit appropriate for collective bargaining in the postal service.'"

The legislative history of the Postal Reorganization Act indicates that Congress modified Section 1202 to delete the reference restricting appropriate collective-bargaining units to national

⁶"The National Labor Relations Board should decide in each case the unit appropriate for collective bargaining purposes in the Postal Service"

craft units and to provide instead that the National Labor Relations Board would decide "in each case" the units appropriate for collective bargaining. Staff of Senate Comm. on Post Office and Civil Service, S. 622-3, 93d Cong., 1st Sess., Explanation of the Postal Reorganization Act and Selected Background Material 155-56 (Comm. Print 1973). In settling on the proposal that the Board determine appropriate units for collective-bargaining purposes, the conference committee stated its intent that the Board determine appropriate units for collective bargaining in the Postal Service on the basis of the same criteria applied by the Board in the private sector. Id. The conference committee deemed it desirable to leave the determination of appropriate bargaining units entirely to the judgment of the Board rather than to pre-determine such matters in any way. Id.

In light of the above statements of congressional intent, the Board determined that Congress did not indicate a desire that

it depart from its traditional community-of-interest approach. United States Postal Service, 208 N.L.R.B. at 953. Thus, the Board considered each of the petitions pending before it on a case-by-case basis, examining in each case factors unique to the postal service along with factors such as geographic proximity, employee interchange, and distinctiveness of job classifications. Id. at 954.

Thus, another statute--one virtually identical to 29 U.S.C. §159(b), enacted by Congress for the purpose of determining bargaining units--has been interpreted by the Board to mean that bargaining-unit determinations are to be made on a case-by-case basis.

D. The Board's new Rule deprives the Board of its Congressionally Mandated Flexibility.

The Seventh Circuit stated that the word "case" means a "proceeding" and that the term is broad enough to cover a rulemaking proceeding as well as an adjudicated one. The Seventh Circuit also

stated that "case" can be an industry or a sub-set or sub-market of an industry; it need not be a particular dispute between a particular employer and a particular union at a particular plant or establishment. American Hospital Ass'n v. NLRB, et al., 899 F.2d at 656. To carry the Seventh Circuit's argument to its logical end, the Board could conceivably promulgate a rule in the aluminum-smelting industry (the industry being a single case, according to the Seventh Circuit's definition), or the tire and rubber industry, or the textile industry, or any other industry, designating the number of appropriate units in each of these industries, or as the Seventh Circuit has put it, in each such case. Such rules would, according to the Seventh Circuit's rationale, comport with the congressional directive that collective-bargaining units be determined on a case-by-case basis. However, this is not what Congress intended when it instructed the Board to determine collective-bargaining units based upon the facts of each individual case.

Congress intended that the Board exercise flexibility in determining bargaining units based on the facts in each case. The Fourth Circuit in NLRB v. Frederick Memorial Hospital, 691 F.2d 191, 194 (4th Cir. 1982), indicated its understanding that Congress intended the Board to maintain flexibility in determining appropriate bargaining units. The Seventh Circuit also has recognized the Board's need to maintain flexibility in determining appropriate bargaining units. NLRB v. Esquire, Inc., 222 F.2d 253, 256 (7th Cir. 1955). In Esquire, Inc., the Seventh Circuit also stated that, given the multiplicity of factors in determining an appropriate bargaining unit, it would be impossible for the Board to formulate rules that could be rigidly applied in all situations. Id. Likewise, this Court has pointed out the difficulty inherent in using inflexible rules to determine appropriate bargaining units, due to the wide variations in employee make-up and the complexities of

modern industrial society. NLRB v. Hearst Publications, Inc., 322 U.S. 111, 134 (1944). See also NLRB v. Bell Aerospace Co., 416 U.S. 267, 294 (1974) (expressed doubt as to the validity of developing a rule that could define all managerial employees).

In 1935, Congress was informed of the need to maintain flexibility in determining bargaining units by Chairman of the National Labor Relations Board Francis Biddle:

It is impossible, however, to lay down a definite rule for the determination of the appropriate unit, for such an attempt would result in rigidity and confusion. The whole system of industrial control and development depends on flexibility, and such considerations must be taken into account as the question of management and supervision, routine employment contracts, existing plans of collective bargaining, and the distinctiveness of the occupation.

Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 83 (1935), Leg. Hist., Vol. I at 1459.

Indeed, Secretary Perkins, who authorized the "in each case" language expressed the importance of flexibility in the Act. Hearings on H.R. 6288 before the House Comm. on Labor, 74th Cong., 1st Sess. 283 (1935), Leg. Hist., Vol. II at 2757. The Board's Rule eliminates the flexibility needed to determine bargaining units appropriate to the factual circumstances of each case.

The Board's need to maintain flexibility in determining bargaining units is evident in the statutory language that units are to be determined "in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter." 29 U.S.C. § 159(b) (1973). An individualized determination of bargaining units appropriate in a particular facility will better assure employees the "fullest freedom in exercising . . . [their] rights." American Hospital Ass'n v. NLRB, et al., 718 F. Supp. 704, 712 (N.D. Ill. 1989) (quoting 29 U.S.C. 159(b)). The history of labor relations in this country

reflects the wisdom of Congress' choice for a dynamic process requiring such flexibility with regard to changing circumstances, company to company.

E. The Substance of the Board's new Rule is Contradicted by the Board's own Decisions and Those of the Various Courts of Appeals.

The Board's Rule that the designated eight units are always appropriate in the acute-care health industry (barring "extraordinary circumstances" which are virtually impossible to find), flies in the face of the Board's own past determinations and those of other courts of appeals. These cases establish that, in fact, these eight units are not always appropriate in every acute-care hospital. See, e.g., NLRB v. Frederick Memorial Hospital, Inc., 691 F.2d 191, 194 (4th Cir. 1982) (unit composed of registered nurses only found to be inappropriate); Long Island Jewish-Hillside Medical Center v. NLRB, 685 F.2d 29, 34-35 (2d Cir. 1982) (unit of registered nurses

limited to one of several divisions of a city-wide hospital found inappropriate); NLRB v. HMO International/California Medical Group Health Plan, Inc., 678 F.2d 806, 809-12 (9th Cir. 1982) (unit composed of registered nurses only found inappropriate); Beth Israel Hospital and Geriatrics Center v. NLRB, 677 F.2d 1343, 1345 (10th Cir. 1981), cert. denied, 459 U.S. 1025 (1982) (unit limited to registered nurses only found inappropriate); Vicksburg Hospital, Inc. v. NLRB, 653 F.2d 1070, 1074-75 (5th Cir. 1981) (unit composed of combined service, maintenance, and technical employees found to be appropriate); St. John of God Hospital, Inc., 260 N.L.R.B. 905, 906 (1982) (unit composed of registered nurses and technical employees found appropriate); Community Health Services, Inc., 259 N.L.R.B. 362, 363 (1981) (unit composed of all professional employees found appropriate); Appalachian Regional Hospitals, Inc., 233 N.L.R.B. 542, 543-44 (1977) (combined unit of service,

maintenance, and technical employees found to be appropriate); Kaiser Foundation Health Plan of Colorado, 230 N.L.R.B. 438, 439 (1977) (unit of registered nurses only found to be inappropriate); Sutter Community Hospitals of Sacramento, 227 N.L.R.B. 181, 184 (1976) (separate units of service and maintenance employees found to be inappropriate).

II.

EVEN IF A RULE PRESUMING EIGHT UNITS MIGHT OTHERWISE BE APPROPRIATE, THE BOARD'S MAKING SUCH A PRESUMPTION IRREBUTTABLE VIOLATES THE SECTION 9(B) "IN EACH CASE" REQUIREMENT.

Although the Seventh Circuit did not believe that Section 9(b) required the Board to make unit determinations on an individual case-by-case basis, the Court also held that such a requirement, to the extent it exists, has been satisfied by the Board's formal rulemaking process. The Seventh Circuit evidently concluded that the gathering of evidence and testimony at the rulemaking hearings satisfied any such case-by-case requirement. However, the

relatively small sampling of evidence adduced at these hearings pales in comparison to the specific evidence adduced at the numerous past trials and hearings held over the years to determine appropriate bargaining units in the acute-care health industry. Contrary to the vast compilation of evidence adduced at these adjudicatory hearings--which conclude that these eight units are not always appropriate--the Board established that eight units are always appropriate, based on its sampling of evidence adduced during formal rulemaking.

It is a fundamental precept of American jurisprudence that true facts are best elicited when there is an adversarial hearing, with opportunity for cross-examination. See, e.g., Sward, Values, Ideology And the Evolution of the Adversary System, 64 Ind. L.J. 301, 316 (1989). In numerous adjudicatory hearings in the past, and regardless of what standard was utilized by the Board or by the particular court, the Board or the court found, as did the courts of appeals, that

craft units or registered-nurse-only units were not appropriate in certain circumstances. However, the present Board, based upon the "truths" that it ascertained during the non-evidentiary "hearings" (consisting of statements and arguments by various special interests) held prior to formulating its Rule, determined that craft units and registered-nurse-only units were always appropriate in the health-care industry.

A fact-specific adjudication with cross-examination will always elicit the truth better than a mere study, no matter how broad. The Board's new Rule creates a presumption that is virtually irrebuttable.⁷ It defies logic that the Board would have the power and authority to

⁷The Court has previously upheld rulemaking by various federal agencies where those agencies have included within their rule a "safety valve" that allows an individual or entity affected by the Rule, a meaningful opportunity to demonstrate that such individual or entity should be excepted from the rule's application because of special circumstances. See, e.g., E.I. duPont de Nemours & Co. v. Train, 430 U.S. 112, 128 (1977); Permian Basin Area Rate Cases, 390 U.S. 747, 771-72 (continued)

create a Rule incapable of contradiction by any employer in the health-care industry, when that Rule is based on "evidence" that is, by its very nature, not of the highest reliability (based on a study, instead of on fact-specific adjudicatory hearings with right of cross-examination) and when the most reliable evidence (that gleaned from such fact-specific adjudications by the Board over the years) itself contradicts the very substance of the new Rule!

It must be concluded that, at the very least, such a presumption, being virtually irrebuttable, does not satisfy the individual-case requirement of Section 9(b).

⁷ (continued)
 (1968); FPC v. Texaco, Inc., 377 U.S. 33, 40-41 (1964); United States v. Storer Broadcasting Co., 351 U.S. 192, 204-05 (1956); National Broadcasting Co. v. United States, 319 U.S. 190, 207, 225 (1943). By contrast, the NLRB's eight-units Rule does not provide affected parties a meaningful opportunity to challenge the Rule's application, since it provides that virtually all of the factors successfully relied on by parties to challenge NLRB unit determinations in the past are no longer viable.

Thus, even if the Board's presumption of eight units in the acute-care health industry is otherwise appropriate, those provisions of the new Rule making that presumption irrebuttable must be struck down. A rule establishing a rebuttable presumption of eight units would at least allow the particular health-care party to rebut the determination as to the appropriateness of the petitioned-for unit by presenting evidence sufficient to overcome the presumption, and such evidence could certainly include the factors considered by the Board and the courts for the past 13 years.

III.

THE BOARD'S EIGHT-UNITS RULE IS CONTRARY TO CONGRESS' ADMONITION TO AVOID UNDUE PROLIFERATION OF BARGAINING UNITS IN THE HEALTH-CARE INDUSTRY.

In 1974, Congress amended the National Labor Relations Act to cover all private health-care institutions, including non-profit hospitals. Act of July 26, 1974, Pub. L. 93-360 §1(a), (b), 88 Stat. 395.

However, due to the fact that health-care institutions provide care for the sick, the aged, and the infirm, Congress sought to provide certain restrictions on unit proliferation in the health-care industry, since patient treatment cannot tolerate the interruptions occasioned by labor disputes.

Because of such concerns, Senator Taft sought to limit the number of bargaining units appropriate in the health-care industry to five.⁸ S. 2292, 93d Cong., 1st Sess. (1973), reprinted in Legislative History of the Coverage of Non-Profit Hospitals under the National Labor Relations Act, 1974, at 457-58. However, Senator Taft withdrew this bill and opted instead for a compromise, an admonition in both the House and Senate Committee Reports expressing Congress' concern that the Board give due consideration to preventing proliferation of bargaining units in the health-care

⁸ 1) All professionals; 2) all technical employees; 3) all clerical employees; 4) all service and maintenance employees; and 5) guards.

industry. S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). Legislative history indicates that Senator Taft withdrew his original bill because of concerns raised that the five-units "Rule" was too rigid and deprived the Board of the flexibility needed to determine units on a case-by-case basis. Legislative History of the Coverage of Non-Profit Hospitals under the National Labor Relations Act, 1974, at 113-114.

The Board and the Courts of Appeals have recognized the Board's obligation to adhere to the congressional admonition in considering the appropriateness of bargaining units in the health-care industry. See, e.g., NLRB v. HMO Int'l/California Medical Group Health Plan, Inc., 678 F.2d 806, 808 (9th Cir. 1982); St. Francis Hospital, 271 N.L.R.B. 948, 951 (1984).

The Rule as promulgated by the Board fails to pay heed to the congressional directive to give due consideration to avoiding proliferation of bargaining units

in the health-care field. The Rule that eight units are appropriate for all acute-care hospitals throughout the country actually promotes unit proliferation, since a lesser number of units would almost never be found appropriate. This concern was aptly stated by Judge Zagel in the district court below:

There are general directives which the Board must follow whenever it makes a unit appropriateness decision in whatever the industry. But Congress drew attention to health care by adding another concern, which must be addressed by the Board in certifying bargaining units in that industry. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, it must use the means least likely to cause unit proliferation to achieve their objective. Although we can agree with the Board that the eight units they establish are appropriate and in many instances may match the natural divisions among the employees and health care institutions, we can envision other divisions, perhaps fewer divisions, in the varied health institutions which would be equally reasonable.

American Hospital Ass'n v. NLRB, 718 F. Supp. 704, 714 (N.D. Ill. 1989).

CONCLUSION

This Honorable Court should hold that the Board's inflexible Rule for acute-care hospitals does not satisfy the case-by-case requirement contained in Section 9(b) of the Act, nor does it give due consideration to Congress' admonition to avoid undue proliferation of bargaining units in the health-care industry. As such, the Rule is invalid and should be stricken. In the alternative, this Court could uphold the presumption of eight units, but allow parties to rebut the presumption with the factors relied upon by employers for the last 13 years.

In light of the foregoing, and due to the fact that when St. Francis Hospital and numerous other similarly situated hospitals are subjected to organizing in a unit designated by the Rule--but otherwise inappropriate--the particular hospitals will certainly test the certification and thereby become embroiled in protracted litigation,

this Honorable Court should grant the
Petition for a Writ of Certiorari.

Respectfully submitted

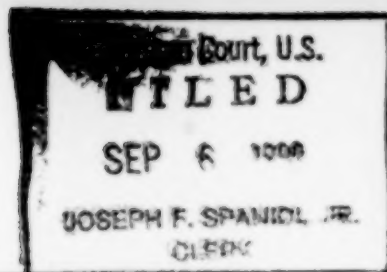
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⑦
No. 90-97



IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

**ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

**BRIEF OF ST. MARGARET MEMORIAL HOSPITAL
AND McKEESPORT HOSPITAL AS AMICI CURIAE
IN SUPPORT OF PETITIONER**

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PARTIES TO THE PROCEEDINGS

In addition to the parties named in the caption, the following entities and individuals were appellants in the court of appeals and are respondents in this Court:

James M. Stephens
Mary M. Cracraft
Dennis M. Devaney
Clifford R. Oviatt, Jr.*
John C. Truesdale
American Nurses Association
American Federation of Labor
and Congress of Industrial
Organization
Building and Construction
Trades Department, AFL-CIO

*Substituted as a respondent pursuant to Rule 35.3 of the Rules of this Court.

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No. 90-97

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, et. al.,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

BRIEF OF ST. MARGARET MEMORIAL HOSPITAL
AND MCKEESPORT HOSPITAL AS AMICI CURIAE
IN SUPPORT OF PETITIONER

STATEMENT OF INTEREST

St. Margaret Memorial Hospital ("St. Margaret") and McKeesport Hospital ("McKeesport") submit this joint brief as amici curiae in support of Petitioner, American Hospital Association ("AHA"). Both McKeesport and St. Margaret are

"acute care hospitals" as defined in Respondent National Labor Relations Board's (the "Board" or "NLRB") Final Rule for Collective-Bargaining Units in the Health Care Industry (the "Final Rule"), 54 Fed. Reg. 16347-16348 (1989); 29 C.F.R. §103.30. McKeesport and St. Margaret, along with all other acute care hospitals, will be directly affected by the Board's Final Rule which was upheld by the United States Court of Appeals for the Seventh Circuit. The AHA has petitioned this Court for a writ of certiorari to review the Seventh Circuit's decision.

St. Margaret Memorial Hospital. St. Margaret is a 287 bed hospital located in Pittsburgh, Pennsylvania which employs approximately 1,300 regular full and part-time employees. Although none of the employees at St. Margaret are represented by a labor organization, a

petition was filed with Region Six of the NLRB on April 27, 1990 by International Union of Operating Engineers, Local 95-95A, AFL-CIO (the "Operating Engineers") by which it seeks to represent a unit limited to 17 maintenance employees.^{1/} That petition is being held in abeyance by the NLRB pending the Court's decision in this case.^{2/}

The Operating Engineers assert that the petitioned-for unit of maintenance employees is appropriate in that it is a "skilled maintenance" unit, one of the eight specific bargaining units now determined to be "appropriate" by the Board in its Final Rule. 29 C.F.R. §103.30(a)(5).

The Seventh Circuit's decision upholding the NLRB's Final Rule, insofar as the Rule deems a separate collective

^{1/} NLRB Case No. 6-RC-10447.

^{2/} See NLRB General Counsel Memorandum, 89-7 (May 30, 1989).

bargaining unit for skilled maintenance employees to be an appropriate unit, is squarely at odds with well established law in the United States Court of Appeals for the Third Circuit, where St. Margaret is situated.^{3/}

Certiorari should be granted to resolve the clear split of authority in the Circuits with respect to the appropriateness of a separate unit of skilled maintenance employees.^{4/} Failure to grant certiorari will result in St. Margaret, and numerous other similarly situated non-profit hospitals, having to pursue needless, costly and time-consuming proceedings and appeals through the NLRB to the Third Circuit and ultimately again before this Court.

^{3/} *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

^{4/} The Second Circuit Court of Appeals shares the Third Circuit's view on the inappropriateness of such units. *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980).

McKeesport Hospital. McKeesport Hospital, located in McKeesport, Pennsylvania, employs 1,552 regular full and part-time employees to care for the needs of patients in its 420 licensed beds. A significant number of the employees at McKeesport are represented for collective bargaining. Nurses (both registered and licensed) are represented in a single unit by the General Staff Nurses Association of McKeesport Hospital, Service Employees International Union, Local 585, AFL-CIO ("Local 585"); skilled maintenance employees are represented by Operating Engineers, Local 95-95A; and the Hospital's service employees are represented by Service Personnel & Employees of the Dairy Industry, Teamsters Local Union No. 205 a/w International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, AFL-CIO (the "Teamsters").

McKeesport's physicians, other professional employees, technical employees, clerical employees, other nonprofessional employees and security guards, are not presently represented.

The recent history of McKeesport is a case study of the disruptive effects of the work stoppages, whipsawing and leapfrogging which Congress feared would be created by the proliferation of health care bargaining units. While the NLRB said that it found little evidence that multiple units have resulted in strikes, jurisdictional disputes and whipsawing, McKeesport's experience in only three bargaining units contradicts this finding and illustrates the disastrous impact that proliferation of bargaining units will have on the future of labor relations in this and other acute care hospitals if the eight unit Final Rule is implemented.

In a period of less than six months in early 1988, McKeesport faced the disruptive effects of the expiration and renegotiation of three labor contracts, three very real threats of economic strike, union organizing campaigns culminating in two NLRB elections and an unexpected, illegal strike by 250 Teamster-represented service employees -- all accompanied by numerous arbitration, agency, NLRB and Court proceedings. Not fully recovered, McKeesport and its patients suffered a three week Nurses' strike in early 1990.

Because of the potential economic and operational impact that the Board's Final Rule has on St. Margaret, McKeesport and other acute care hospitals, and the disruption that will occur if the validity of the NLRB's Final Rule is not finally determined, we submit this brief in support of the AHA's

Petition and urge the Court to grant the Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit. The Final Rule is contrary to Section 9(b) of the National Labor Relations Act (the "Act" or "NLRA") and Congress' 1974 admonition against proliferation of bargaining units in health care institutions. The NLRB Final Rule will exacerbate the extant burden of health care costs against Congress also admonished in 1974.

SUMMARY OF ARGUMENT

The cases of St. Margaret and McKeesport convincingly illustrate the adverse effects that the Court's failure to grant the AHA's Petition will have on the health care industry. While this brief deals with the situations of only two of the more than 5,000 hospitals potentially affected by the Final Rule, a

similar impact on many other institutions is imminent. Moreover, the concerns which caused the authors of the 1974 Health Care Amendments to the NLRA, Pub. L. No. 93-360, 88 Stat. 395, to recognize the need to afford hospitals special protection to minimize the adverse effects of work stoppages and other disruptions to safe patient care have now taken on new proportions. The cost of healthcare has continued to skyrocket, threatening to make proper care unaffordable for many Americans. It has never been more important than the present to protect the public interest by affording hospitals the safeguards which Congress envisioned to be necessary when it admonished the Board to 'avoid undue proliferation of bargaining units in hospitals.

The legislative history of the 1974 Health Care Amendments, by which Congress expanded the NLRB's jurisdiction to cover

not-for-profit hospitals, makes clear that Congress considered proliferation of units a danger to patient care and feared that it would lead to increased costs for medical care. To address these concerns, the Congressional committees responsible for the legislation very purposefully included language in their committee reports directing that:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry.

S. Rep. No. 93-766, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S. Code Cong. & Ad. News, pp. 3946, 3950; H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

Senator Taft, one of the primary sponsors of the legislation, explained the rationale for this "Congressional admonition":

I believe this is a sound approach and a constructive compromise, as the Board should be

permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented.

In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

The committee in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases.

120 Cong. Rec. 12944-45 (1974)

While paying only "lip service" to Congress' admonition against unit proliferation by saying it was "entitled to our respectful consideration", American

Hospital Association v. NLRB, 899 F.2d 651, 658 (7th Cir. 1990), the Seventh Circuit concluded that the Board's Final Rule did not constitute undue proliferation in conflict with Congress' intention when it passed the 1974 Health Care Amendments. St. Margaret and McKeesport agree with the AHA that the Seventh Circuit's conclusion is in conflict with decisions of the Courts of Appeals for the Ninth and Tenth Circuits. Moreover, St. Margaret and McKeesport believe the Seventh Circuit's decision is also at odds with decisions of the Court of Appeals for the Third Circuit and has created a clear and irreconcilable split in the courts of appeals insofar as the decision upholds the validity of a separate maintenance employee unit. Finally, McKeesport's experience colorfully illustrates that the Court of Appeals' decision is also flawed inasmuch

as it sanctions the Board's erroneous conclusion that the work stoppages, whipsawing and leapfrogging feared by Congress when it extended the Act to cover non-profit hospitals, has not occurred in hospitals with multiple bargaining units.

A. The Court Of Appeals' Decision Affirming The Validity Of The NLRB's Final Rule Creates A Clear Split In The Circuits Insofar As The Rule Provides That A Separate Unit Of Skilled Maintenance Employees Is Appropriate.

In its Final Rule, the NLRB reversed the position that it took in its first Notice of Proposed Rulemaking ("NPR I"), 52 Fed. Reg. 25142 (1987), and in many of its earlier decisions,^{5/} and determined that a separate unit of skilled maintenance employees is now appropriate. While the Board has also approved

^{5/} See, e.g., *Shriners Hospital*, 217 NLRB 806 (1975); *Jewish Hospital Association*, 223 NLRB 614 (1976); and *Peter Bent Brigham Hospital*, 231 NLRB 929 (1977).

separate units of maintenance employees in other cases, the Board's attempts to certify such units on a case-by-case basis have not once met with approval by the courts of appeals.^{5/} In spite of this fact, the NLRB, with the approval of the Seventh Circuit, now seeks to mandate through rule-making what it was unable to obtain through adjudication.

The Third Circuit has twice examined and rejected separate units of hospital maintenance employees. In *St. Vincent's Hospital v. NLRB*, *supra*, the issue before the Third Circuit was the NLRB's certification of a separate unit consisting primarily of boiler room employees. In refusing to enforce the NLRB's certification of the unit, the Third Circuit exhaustively reviewed the

^{5/} See, e.g., *Mercy Hospital Association*, 238 NLRB 1018 (1978), enforcement denied 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 791 (1980); *Allegheny General Hospital*, 239 NLRB 872 (1978), enforcement denied 608 F.2d 965 (3d Cir. 1979); *St. Vincent's Hospital*, 223 NLRB 614 (1978), enforcement denied 567 F.2d 588 (3d Cir. 1977).

legislative history of the 1974 Amendments and, in consideration of Congress' admonition against proliferation, stated:

[t]he legislative history of the health care amendments, however, makes it quite clear that Congress directed the Board to apply a standard that was not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital.

567 F.2d at 592. The Third Circuit proceeded to explain that the Board's use of its traditional factors for determining unit appropriateness in hospitals violated the Congressional admonition against undue proliferation. The court added:

[T]he factors of amount of contact between workers, separate immediate supervision, and the special skills of certain crafts

must be put in balance against the public interest in preventing fragmentation in the health care field. A mechanical reliance on traditional patterns based on licensing, supervision, skills and employee joint activity simply does not comply with congressional intent to treat this unique field in a special manner.

Id. (emphasis added.) The Court thus refused to enforce the Board's order directing St. Vincent to bargain with the separately certified unit.^{1/}

The NLRB, however, later disagreed with the Third Circuit's analysis in *St. Vincent's* and certified a separate unit of maintenance employees in *Allegheny General Hospital*. The Board discussed

^{1/} The Third Circuit in *St. Vincent's* noted its reliance on the Board's earlier decisions in *Shriners Hospital* and *Jewish Hospital Association* to be the correct expressions of the law properly recognizing the considerations to be applied by the Board. In *Shriners*, the Board said: "... mindful of the congressional mandate and in the exercise of our discretion, we find that in the health care industry the only appropriate unit for collective bargaining which encompasses stationary engineers is a broad unit consisting of all service and maintenance employees of the employer, excluding professionals and business office clericals. 217 NLRB at 808 (emphasis added).

the Court's holding in *St. Vincent*:

In *St. Vincent's Hospital v. NLRB*, the court decided that the legislative history of the 1974 amendments to the Act, specifically the statement in the accompanying Senate and House committee reports that "[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry," and the explanations of it offered by certain sponsors of the amendments, precluded the Board from finding appropriate separate units of maintenance and powerhouse employees at health care institutions After carefully reconsidering the legislative history of the 1974 amendments, we have concluded that, with all due respect to the court, Congress did not intend to prohibit such units.

239 NLRB at 872 (footnotes omitted).

The Third Circuit, in *Allegheny General Hospital v. NLRB*, refused to enforce the Board's order. The Court stressed that the case presented "a most unusual circumstance in which a federal agency has refused to apply the law announced by the federal judiciary." 608 F.2d at 968. Refusing to reappraise its

St. Vincent's decision, the Third Circuit emphasized that the NLRB had neither the power nor authority to disagree with the decisions of the court, then instructed the Board concerning the fundamental doctrines of *stare decisis* and the power of the federal judiciary to interpret statutes. The Third Circuit emphatically concluded that "for the Board to predicate an order on its disagreement with this court's interpretation of a statute is for it to operate outside the law." 608 F.2d at 970 (emphasis added).

By adopting its Final Rule, the Board is now attempting to achieve through rule-making precisely what the Third Circuit and other courts of appeals have held that it may not achieve through adjudication. Citing the refusal of the courts to approve such units, the NLRB did not propose a separate unit of skilled maintenance employees to be

appropriate in NPR I. But, the Board reversed its position in its Second Notice of Proposed Rulemaking ("NPR II") 53 Fed. Reg. 33900, 33920 (1988), and concluded that skilled maintenance employees "can and should constitute a separate appropriate bargaining unit." To reach this conclusion, however, the NLRB did exactly what the Third Circuit instructed it not to do in health care cases, that is to mechanically rely upon traditional community-of-interest factors in formulating its rule, without considering the effects of unit fragmentation or the special public interest in hospital unit determination. *Allegheny General v. NLRB*, 608 F.2d at 971.

The conflict between the decisions of the Third Circuit and the Seventh Circuit with respect to a separate skilled maintenance unit could not be more apparent. The Third Circuit clearly

held in *St. Vincent's*, and reaffirmed in *Allegheny General*, that the NLRB's reliance on traditional community-of-interest factors "simply does not comply with the Congressional intent to treat this unique field in a special manner." *St. Vincent's v. NLRB*, 567 F.2d at 592. The Seventh Circuit's decision does not even address the question of whether the Congressional admonition against the proliferation of bargaining units in hospitals requires more than the Final Rule's apparent reliance upon traditional community of interest criteria.

Quite clearly, the NLRB's Final Rule as approved by the Seventh Circuit disregards the decisions of the Third Circuit and its interpretation of the Board's governing statute, notwithstanding the court's chastisement of the Board in *Allegheny General*. Consequently, if faced with this question again,

the Third Circuit will almost certainly conclude that the Board is operating "outside the law" in its attempt to mandate by Rule a separate unit of skilled maintenance employees.

In the *St. Margaret* case, the Operating Engineers have petitioned the NLRB for an election in a skilled maintenance unit limited to 17 of the hospital's approximately 1300 employees. Under the Final Rule, upheld by the Seventh Circuit, such a unit would be appropriate. In light of the clear Third Circuit precedent, which holds that a separate skilled maintenance unit is not appropriate, *St. Margaret* is in the untenable position of having to acquiesce to a unit determination which the Third Circuit has held to be unlawful and contrary to Congress' admonition against proliferation, or to go through the expense and uncertainty of challenging

the NLRB's Rule by refusing to bargain, and seek review in the Third Circuit.

Unfortunately, adjudication by the Third Circuit would not be immediate nor would it be without considerable time and expense on the part of St. Margaret and other hospitals similarly affected. If this Court were to deny the extant Petition for a Writ of Certiorari and allow the Final Rule to take effect, the NLRB Regional office would immediately resume processing the pending representation case now held in abeyance.

Since the Board would find the skilled maintenance unit appropriate under its Final Rule, the result would certainly be a Decision and Direction of Election by the NLRB Regional Director. Although the Hospital would procedurally be required to Request Review by the NLRB of the Regional Director's determination, the Request would be denied, again

because of the Rule, and an election would be conducted. The Board's unit determination in a representation proceeding pursuant to Section 9(b) of the Act and the denial of a Request for Review are not directly reviewable by the courts of appeals. *American Federation of Labor v. NLRB*, 308 U.S. 401 (1940).

In order to reach the court of appeals for review, it would be necessary for St. Margaret to "test the certification" by refusing to bargain with the Operating Engineers, thereby deliberately committing an unfair labor practice, forcing the NLRB to issue an appealable bargaining order against the Hospital. The proceedings attendant with investigation of the unfair labor practice charge, the issuance of and response to a formal Complaint and Notice of Hearing before an Administrative Law Judge, and an appeal to the Board, would take several months

to more than a year and would be very costly for the Hospital.

Only after the NLRB rules on the case may the Hospital bring a Petition for Review by the Third Circuit and/or may the NLRB petition the court for Enforcement. Again, the time frame for petitioning and obtaining a decision by the Court of Appeals may take several additional months to a year or more.

During the two to three years during all the described obligatory legal proceedings, both the Operating Engineers and St. Margaret will be required to expend tremendous amounts of money, effort and time advocating and protecting their respective positions. A side effect of this process is that during the pendency of the unfair labor practice charges, employers oftentimes act at their own peril by making changes in wages, hours or working conditions

without bargaining with the union. The risk, in the event that the certification is determined to be valid, is that the employer may be required to rescind all such changes. Back pay liabilities may accrue. Since employers are very reluctant to make changes under these circumstances, such restraints are very disruptive of employee morale, productivity and, in a hospital, a distraction from patient care. Finally, and significantly, the Union would be free at any time to protest the hospital's refusal to bargain by striking St. Margaret. The expenses attendant with a hospital's exercise of its rights to have its "day in court," particularly in the Third Circuit where there exists a high probability the hospital will prevail, add to the cost of providing its health care and, in a different vein, again runs afoul of Congress' concerns.

Significantly, the St. Margaret case is only one of three cases involving skilled maintenance units presently filed and pending in Region Six of the NLRB in Pittsburgh, Pennsylvania. The Operating Engineers have also filed petitions seeking to represent skilled maintenance units at Central Medical Center and Shadyside Hospital, both located in Pittsburgh.^{8/} There is a clear potential for many more such petitions to be filed, resulting in additional costly, time consuming and disruptive appeals to the Third Circuit.^{2/}

^{8/} NLRB Case Nos. 6-RC-10445 and 6-RC-10446.

^{2/} The law firm of Cohen & Grigsby represents approximately 35 acute care hospitals within the jurisdiction of the Third Circuit Court of Appeals and is aware of several other organizing campaigns for hospital skilled maintenance units by the Operating Engineers. Many of those campaigns will result in additional NLRB representation petitions limited to skilled maintenance units as soon as the injunction/stay preventing the NLRB from implementing its Final Rule is lifted. We have reason to expect in excess of ten, and possibly more, petitions to be filed shortly after the Rule is permitted to go

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The Court can prevent the disruptive effects of such case-by-case challenges of the Board's Final Rule by granting the Petition for a Writ of Certiorari in this case and by resolving the clear conflict between the Circuits.

B. Proliferation Of Bargaining Units Leads To The Types Of Problems Congress Feared When It Passed The 1974 Health Care Amendments.

Congress' concern about proliferation of bargaining units in hospitals was based upon a fear that proliferation would lead to numerous work stoppages, jurisdictional disputes, and wage and benefit whipsawing and leapfrogging, which, in turn, would add to the already skyrocketing costs of medical care. See p. 8-10, *supra*. The Board, in NPR II, examined the "evidence" presented in

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into effect. Each hospital so petitioned must individually pursue the costly and circuitous route through the NLRB to the Circuit to preserve its rights and remedies.

connection with its rule-making procedure and concluded that there was "little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation." 53 Fed. Reg. at 33908. As the AHA points out, however, "the Board's 'finding' ignores the fact that there has not been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach."^{10/} AHA Petition at 22. The Seventh Circuit's sanctioning of the NLRB's clear disagreement with Congress and the courts over the effects of unit proliferation in itself warrants review by this Court.

^{10/} By the Board's own admission, its evidence showed that only about 10% of organized hospitals negotiate three or more contracts. 53 Fed. Reg. at 33908. For the Board to conclude on the basis of that record that eight units are appropriate and that such proliferation will not lead to the problems feared by Congress is, as the AHA notes, "sheer speculation." AHA Petition at 22.

McKeesport is an example of a hospital that has experience negotiating and administering contracts with multiple bargaining units. Although the three bargaining units at McKeesport are several fewer than the eight permitted by the Final Rule, McKeesport's experience in dealing with multiple units is indicative of the problems hospitals will face when multiple units are certified by the NLRB. McKeesport's labor history graphically illustrates the future of hospital bargaining if the Final Rule is permitted to stand. Contrary to the NLRB's "finding" in NPR II,^{11/} McKeesport's experience has been that multiple units have resulted in multiple work stoppages and threats of work stoppages, wage and benefit whipsawing and leapfrog-

^{11/} The Board does not discuss the effects of proliferation in its Final Rule other than to note that it had thoroughly considered such arguments in NPR I and NPR II and that no further consideration or response was required. 54 Fed. Reg. at 16337.

ging, multiple contract negotiations, labor arbitrations and other matters which cause significant disruptions to patient care and contribute to escalating health care costs. In short, McKeesport's recent history proves that the concerns expressed by Congress as it passed the 1974 Health Care Amendments remain valid, and in McKeesport's case, have come to fruition.

As mentioned above, McKeesport has three units of represented employees. It has the potential for five, or even six, additional units under the NLRB Final Rule. Contracts for all three of McKeesport's units were due to expire in the first half of 1988. In December 1987, Teamsters Local 205, which already represented the Hospital's service employees, petitioned the NLRB for an election in a unit of technical and clerical employees. An election was

scheduled for February 19, 1988. SEIU Local 585 and Office and Professional Employees International Union, Local 457, AFL-CIO, also secured places on the ballot and became involved in the organizing campaign.

During the election campaign, in what is widely-believed to have been a show of strength intended to influence the election and "whipsaw" the Hospital, the service employees represented by the Teamsters walked off their jobs, without giving the Hospital notice as required by Section 8(g) of the Act, 29 U.S.C. §158(g).^{12/} In fact, the Teamster walkout

^{12/} In NPR II, the Board suggested that hospitals seek common expiration dates to solve problems caused by recurring near-strikes including multiple §8(g) strike notices. 53 Fed.Reg. at 33909. Not only is such a suggestion incredibly naive, ignoring as it does the realities of hospital bargaining, but McKeesport's experience has shown that contemporaneous expiration dates actually exacerbate problems rather than solve them. Unions have recognized the bargaining leverage separate expiration dates provide. It is thus highly unlikely that a self-respecting union

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came without any warning. It was also in derogation of a no-strike clause in the labor agreement.^{13/} When the employees refused to return to work, McKeesport had no choice but to replace employees participating in the illegal walkout.

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would simply give away this leverage in order to serve the public interest of forestalling problems caused by recurring near strikes. Even assuming that a hospital could negotiate common expiration dates, that would not assure that all of its unions would give simultaneous §8(g) strike notices. The timing of such notices is entirely within the discretion of the union. If a union was inclined to work beyond the contract expiration date, it could simply delay giving its §8(g) notice and unions acting in concert could "whipsaw" the hospital to death through sequential and multiple notices of an impending strike. The hospital would then be forced either to allow the employees to work under the expired contract or to lock them out and cause a disruption of its operations. Following the Board's suggested approach would virtually require a hospital to close down and lay off non-striking employees every time the multiple contracts were set to expire. Planning to operate a hospital under the simultaneous threat of multiple work stoppages would be virtually impossible.

^{13/} This was not the first time that the Teamsters had staged an illegal walkout. On at least one prior occasion in 1986, the Union engaged in the same tactic. The Union had also threatened, on numerous occasions, to walk out in support of its grievances.

As could be expected, the illegal walkout and McKeesport's reaction triggered a flurry of legal actions. McKeesport filed unfair labor practice charges against the Union for violation of Sections 8(g) and 8(b)(1)(A) of the Act, 29 U.S.C. §§158(g), 158(b)(1)(A), and brought suit in federal court seeking, *inter alia*, damages under Section 301 of the Labor-Management Relations Act, 29 U.S.C. §185. The Teamsters, for its part, also filed unfair labor practice charges and grieved the Hospital's decisions to terminate and replace its members. After the parties disputed the arbitrability of the grievances, the Union brought suit in federal court to compel arbitration.^{14/}

Contemporaneous with the illegal Teamsters strike, negotiations had begun

^{14/} All of these various suits, unfair labor practice charges and other legal proceedings were settled by the parties approximately three months after the illegal strike.

with SEIU Local 585 for the nurses' unit. Local 585 was involved in the NLRB election campaign for the technical/clerical unit and obviously sought to use the negotiations to bolster its chances of victory in the election.^{15/} In this charged environment, the nurses came to the bargaining table disgruntled about perceived wage inequities and fringe benefit disparities in the expiring contract. At the bargaining table, Local 585 sought to make up for these perceived disparities and demanded substantial increases. As negotiations continued, Local 585 informed the hospital that it would strike on March 22, 1988.

In response to Local 585's Section 8(g) strike notice, McKeesport had no choice but to take the steps that any

^{15/} The first election in the proposed technical/clerical unit was held on February 19, 1988. No union received a majority vote. The NLRB then scheduled a run-off between the Teamsters and "No Union" on March 17, 1988. At the March 17 run-off election, the employees voted to remain unrepresented.

prudent hospital must take to protect the well being of patients when faced with a Section 8(g) strike notice. Thus, McKeesport began to curtail admissions, canceled elective surgeries and began preparations to transfer patients to other institutions. McKeesport also began to implement plans to lay-off other employees and to consolidate operations by closing several hospital units. Fortunately for McKeesport's patients and the community, the Hospital and Local 585 reached agreement on the eve of contract expiration, thereby averting a strike.^{16/}

The agreement with Local 585 provided for significant economic increases. Because of Local 585's leverage, and in the context of the

^{16/} Contrary to the NLRB's assumptions, Section 8(g) has been somewhat of a mixed blessing. While it undoubtedly protects hospitals and their patients when a strike does occur, it places a burden upon hospitals and their patient community in the many more cases where the contract is settled short of a strike, almost always at the eleventh hour after the 8(g) notice and the hospital's prudent preparatory response.

ongoing Teamster troubles, the Hospital was pressured to accede to many Union demands since a nurse's strike most assuredly would have closed the Hospital for the duration of the strike, and quite possibly could have forced permanent reductions in the Hospital's operations due to the concurrent lingering effects of the Teamsters' walkout.

Shortly after narrowly averting a strike by the nurses, McKeesport was again involved in difficult contract negotiations -- this time with Teamsters Local 205.^{17/} These negotiations were conducted in the very charged environment following the Teamsters' election defeat and the many legal and other disputes between the Teamsters and the Hospital occasioned by the illegal walkout.

^{17/} The Teamster agreement expired May 1 and the negotiations actually had begun before March 22 while the Nurses' negotiations were still in progress.

Just two months later, the Hospital faced the expiration of the Operating Engineers contract who also demanded a hefty increase, leveraging off the effects of the labor disputes with SEIU and the Teamsters. Once again, the Hospital was compelled to seek to maintain labor peace and recognize the Operating Engineers' leverage. After the illegal Teamsters' walkout and the near strike by the nurses, McKeesport could not risk further negative effects from another work stoppage or the attendant legal costs if it had to face a strike by its maintenance workers, who, while small in number, occupied positions critical to continued operation of the Hospital.

Before McKeesport had fully recovered from the 1988 labor problems occasioned and exacerbated by the multiple units, the Hospital was faced with a new, serious threat. The nurses'

contract with Local 585, negotiated in 1988, expired in the spring of 1990. Unlike 1988, however, the parties were unable to reach agreement in time to prevent a strike. The work stoppage lasted from March 1 until March 17, 1990. The impact on patient care and other hospital operations was dramatic. Once again, the hospital had to implement its strike contingency plans even before the strike began. Admissions were curtailed, non-essential surgery was cancelled, and patients, some seriously ill, were transferred by ambulance to other institutions. The hospital had to "staff-down" because of the strike and in the process laid off hundreds of service, maintenance, technical, and clerical employees.

The lay-offs and subsequent recall of these employees engendered further labor disputes. Numerous employees grieved either their initial lay-off or

circumstances relating to their recall. At present, there are over 50 such grievances awaiting arbitration. Other side effects of the lay-offs include severely dampened employee morale and heightened tensions between the various units of Hospital employees. McKeesport expects that these and other problems resulting from the nurses' strike may continue well into the future.

McKeesport's 1988 labor problems from its multiple units and the experience with the 1990 nurses' strike resoundingly affirm the validity of Congress' concerns upon passage of the 1974 Health Care Amendments. With the Teamsters, Operating Engineers and Local 585 contracts all expiring within the same general time period, each union used the other unions' threats, demands and bargaining gains as leverage to gain agreement for its own bargaining propos-

als. Further, we submit, both the Teamsters and Local 585 undoubtedly used the negotiations to attempt to influence the NLRB election in the technical/clerical unit.

Finally, the nurses' strike caused disruptions not only in patient care but in the Hospital's relationship with its other Unions. The end result of these activities by multiple units was precisely the kind of whipsawing, leap-frogging and work stoppages that Congress feared when it passed the Health Care Amendments. Despite these experiences, which undoubtedly are or will be repeated at other hospitals with multiple units, the NLRB found little "evidence" that Congress' concerns were valid. That conclusion is flawed.

The time, effort and expense associated with negotiating and administering contracts with multiple units has

dramatically increased non-patient care related operating costs at McKeesport.^{18/} Such costs will certainly increase exponentially if the NLRB's eight unit Final Rule is permitted to stand, all at a time when Congress and the public have become increasingly alarmed about rising health care costs.

Increases in medical costs resulting from unit proliferation was clearly a primary concern of Congress in 1974 as it passed the Health Care Amendments. Senator Taft very specifically warned that "the cost of medical care in this

^{18/} For example, in its Final Rule, the Board itself cites evidence revealing that negotiation of a single collective bargaining agreement can cost between \$15-40,000 in legal fees alone. 59 Fed.Reg. at 16339. Other costs for negotiations which are also very significant include staff time devoted to actual bargaining, costs associated with surveying local wage rates in other institutions, drafting and costing contract proposals and counter-proposals, studying the potential impact of proposals on operations and clerical duties related to the preparation of draft proposals, bargaining notes and final proposals. Unless some economics could be achieved, these costs potentially would be multiplied eight times if the Board's Final Rule is permitted to stand.

country ha[d] already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors."^{19/} Congress' concern applies with even more urgency in today's economy. Thus, it is imperative that the NLRB pay heed to Congress' admonition and recognize this important public interest in preventing unit proliferation.^{20/}

^{19/} As the legislative history shows, this was a primary concern that caused Congress to issue its express mandate against undue proliferation. 120 Cong. Rec. 12944-45 (1974). See *supra* pp. 9-10.

^{20/} Many acute-care hospitals today receive a majority of their funding from federal Medicare and similar state Medical Assistance programs. At McKeesport, for example, about 68% of all admissions are paid for by Medicare or the Pennsylvania Medical Assistance Program. Other Southwestern Pennsylvania hospitals compare at approximately 67%. *Hospital Costs Rise 17.4%*, Pittsburgh Post-Gazette, Aug. 14, 1990 at 6 Col. 2. As a result, public funds budgeted for these critical programs, which would otherwise be used in direct patient care activities, will, by necessity, be used to cover increased operating costs resulting from strikes, multiple negotiations, whipsawing and leapfrogging. The public interest is not served by diverting public funds from critical health care programs to cover non-

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The NLRB in its rulemaking did not consider the public interest in affordable health care as a factor militating against unit proliferation. Rather, in its Final Rule the Board concluded:

The statutory amendments enacted by Congress in 1974 represented an implicit policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the cost.

54 Fed. Reg. 16339. (emphasis added.)

The Board simply brushed aside Congress' express policy decision that unit proliferation should be prevented because of its negative impact on health care costs. By upholding the Board's Final Rule, the Seventh Circuit has sanctioned the Board's clear departure from Congress' intent.

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patient care activities, thereby decreasing the quality and amount of health care available to people who rely on such programs.

The experience of McKeesport in dealing primarily with only three units, instead of the eight units set forth in the Final Rule, is compelling evidence that the proliferation of units in hospitals not only causes disruptions to patient care by work stoppages, multiple contract negotiations and whipsawing and leapfrogging, but also increases medical costs and threatens the financial stability of hospitals which encounter these tactics effectively utilized by unions.

This Court should grant certiorari to redress the Seventh's Circuit's sanctioning of the Board's erroneous "finding", especially where the Final Rule clearly creates the types of problems that concerned Congress when it extended the Act to non-profit hospitals.

CONCLUSION

For the foregoing reasons, St. Margaret Memorial Hospital and McKeesport Hospital, amici curiae, respectfully suggest that the Court grant the Petition for Writ of Certiorari and reverse the Court of Appeals' decision.

Respectfully submitted,

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In The
Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The
United States Court Of Appeals For The
Seventh Circuit

BRIEF OF THE MISSOURI HOSPITAL ASSOCIATION
AND ILLINOIS HOSPITAL ASSOCIATION AS
AMICI CURIAE IN SUPPORT OF PETITIONER

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**STATEMENT OF INTEREST OF THE
MISSOURI HOSPITAL ASSOCIATION AND THE
ILLINOIS HOSPITAL ASSOCIATION
AS AMICI CURIAE**

This brief is submitted on behalf of the Missouri Hospital Association ("MHA") and Illinois Hospital Association ("IHA") in support of petitioner, the American Hospital Association ("AHA"). The Missouri Hospital Association was an active participant in the hearings before the National Labor Relations Board ("Board") concerning the promulgation of the rule governing collective bargaining units in the health care industry. The MHA offered testimony through two of its leading health care executives and submitted written comments to the Board. The MHA also participated as an *amicus curiae* before the court of appeals for the Seventh Circuit.

The MHA has 139 acute-care hospital members, representing 98 percent of the acute-care hospitals in the state of Missouri. The IHA has 211 acute-care hospital members, representing virtually all of the acute-care hospitals located in the state of Illinois. The membership of both associations ranges from large tertiary care referral centers in major metropolitan areas to very small primary care hospitals in rural areas. The diversity of the MHA and the IHA membership and the general diversity of the health care industry in Missouri and Illinois are of particular relevance to the issues in the AHA's petition. The MHA's and IHA's member hospitals are health care industry employers subject to the rule promulgated by the Board. As such they and the patients they serve have a significant and direct interest in the granting of the AHA's petition.

The MHA and IHA agree with the AHA's legal position that the rule promulgated by the Board violates both the mandate of Section 9(b) of the National Labor Relations Act (the "Labor Act") that bargaining unit determinations be made "in each case," and the Congressional admonition against undue proliferation of bargaining units in the health care industry, contained in the legislative history of the 1974 Health Care Amendments to the Labor Act. The MHA and IHA rely upon the arguments made by the AHA in support of those positions. The MHA and IHA, as *amici*, will not restate those arguments but will focus on Missouri's and Illinois' experience and demonstrate 1) the necessity of individualized bargaining unit determinations in light of the diverse and rapidly changing health care industry, 2) the proliferation of bargaining units in acute-care hospitals that necessarily will follow application of the rule, and 3) the potential adverse impact upon health care of hospital-by-hospital challenges to the validity of the bargaining unit rule.

The Board has concluded that there are no differences among acute-care hospitals which are relevant to bargaining unit determinations. The MHA and IHA find this conclusion to be incredible and irrational in light of the wide range of hospital organizations and their relationships with their employees. In this regard, Missouri and Illinois are microcosms of the country, with major metropolitan hospitals at one end of the spectrum and small rural hospitals at the other. The MHA and IHA, as representatives of the vast majority of Missouri and Illinois hospitals, believe they have information relevant to this Court's consideration of the AHA's petition for a writ

of certiorari to the United States Court of Appeals for the Seventh Circuit.

REASONS FOR GRANTING THE PETITION

I. THE DIVERSE AND RAPIDLY CHANGING HEALTH CARE INDUSTRY REQUIRES INDIVIDUALIZED BARGAINING UNIT DETERMINATIONS.

Section 9(b) of the Labor Act provides, in part, that: The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof

28 U.S.C. § 159(b) (emphasis added). The mandate of this language is clear: the Board must determine the appropriateness of a bargaining unit on an individual basis, considering the particular facts at hand. The Board, by promulgating an essentially irrebuttable rule for determining bargaining units in acute-care hospitals, has shirked its statutory responsibility to conduct this factual review and make an individual decision.

The Board's Final Rule provides that "[e]xcept in extraordinary circumstances . . . the following shall be appropriate units, and the only appropriate units" and lists eight separate bargaining units. Final Rule, 54 Fed. Reg. 16347-16348 (1989). The only specific example of an "extraordinary circumstance" given by the Board is "a unit of five or fewer employees." *Id.* at 16348. In the Supplementary Information accompanying the Final Rule the Board reaffirmed the narrow scope of the "extraordinary circumstances exception" as previously set forth in its Second Notice of Proposed Rulemaking ("NPR II"). *Id.* at

16345. In NPR II the Board, in addressing variations between acute-care hospitals, stated that

The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions.

NPR II, 53 Fed. Reg. 33932.¹ This sweeping dismissal of any further consideration of the diversity of acute-care

¹ The Board provided the following enumeration of "minor differences" in acute-care hospitals:

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nationwide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building.

NPR II, 53 Fed. Reg. at 33932.

hospitals as "merely minor differences" is a flagrant violation of the "in each case" requirement of Section 9(b) and flies in the face of any realistic analysis of the health care industry. The court of appeals decision upholding the validity of the bargaining unit rule also ignores the importance of the differences among acute-care hospitals.

A. The Board's Rule Is Arbitrary And Capricious In That It Ignores The Diversity Of Acute-Care Hospitals.

The variations in the hospital industry in Missouri, as elsewhere, hardly can be considered "merely minor differences" as the Board concluded. The MHA submits that such variations are significant and are relevant to the determination of bargaining units. The Board's rule is arbitrary and capricious in that it ignores any and all differences among acute-care hospitals. In support of its position, the MHA offers the following information concerning the diversity of the hospital industry in Missouri.

There are 142 acute-care hospitals in Missouri, 139 of which are members of the MHA. Of the member hospitals, seventy-two are rural and sixty-seven are urban.² The largest member hospital has 1,208 licensed beds and the smallest has eighteen licensed beds. The member hospital with the largest staff employs the equivalent of 5,262 full-time employees; the smallest employs twenty-eight. The number of full-time registered nurses employed by member hospitals ranges from 1,201 to three.

² The terms "rural" and "urban" as used for purposes of MHA statistics are as defined in the Medicare Regulations at 42 C.F.R. § 412.62(f).

Forty-five member hospitals have beds designated as "swing beds," i.e., beds which may be designated from time to time either as skilled nursing care beds or acute-care beds at the discretion of the institution. Forty-five member hospitals have long-term care or nursing home units which are operated either in separate locations, in separate buildings on the hospital campuses or on separate floors within the hospitals' main buildings.

The services provided by the MHA member hospitals, and their related organizations, also vary widely. Some member hospitals provide basic inpatient and outpatient general care services while others operate, often through subsidiary corporations, activities such as home health agencies, inpatient and outpatient psychiatric units, multi-location outpatient clinics, outpatient surgical facilities and rehabilitation facilities.

Each of these types of hospitals and, indeed, each of these hospitals, has a different employee mix and a different administrative structure. They have different ratios of one type of employee to another and of all employees to patients as well as different levels of integration among various employee groups. It should not require evidence or hearings to conclude that the employees of a twenty bed hospital in rural Denton County, Missouri are organized in a different fashion than the employees of a 1,200 bed hospital in metropolitan St. Louis, Missouri. The patient acuity levels are substantially higher at the latter institution than at the former. Generally speaking, the higher the acuity level of the particular institution, the more skills that must be brought to bear upon each patient's needs at the same time. Thus, the higher the acuity, the greater the functional integration of the many levels of employees needed to care for a single patient.

On the other hand, the large urban institution, with thousands of employees, is more likely to be able to hire fairly narrow specialists and concentrate their responsibilities within their primary area of expertise while the rural hospital, with far fewer employees, must ask each employee to wear more hats and fill more roles. While a well-baby clinic in a rural hospital might have relatively few employees and disciplines applied to each patient, an intensive care unit in a tertiary referral center would require a large number of multi-disciplined employees working closely together to administer care.

An example of the high level of integration of the various classifications of health care employees is found in the fact that at one acute-care hospital in Kansas City, with only 240 staffed beds, registered nurses work in fifteen departments and occupations in addition to being staff nurses or operating room nurses.³ These registered nurses work in utilization review, risk management, quality assessment, social services, education, a preferred provider organization, medical records, admitting, administration, outpatient clinics, radiation therapy, central services, DRG coordination and review, employee health, infection control and the wellness clinic. At that institution, approximately 10 percent of the nurses are not in patient-care areas and only 70 percent are in traditional acute patient-care settings.⁴ Nonetheless, the Board

³ See, Testimony of Dan H. Anderson, Supplemental Appendix of Plaintiff-Appellee submitted to the court of appeals for the Seventh Circuit ("S.A.") at 482.

⁴ See, November 6, 1987 letter to counsel for American Federation of Labor and Congress of Industrial Organizations, submitted to the Board as part of the administrative record.

would require all of these registered nurses from the many different departments, who have virtually nothing in common with each other except their state licensure but a great deal in common with other employees with whom they work on a daily basis, to be lumped into a single bargaining unit separate from all other employees. Such a result confounds reason and arbitrarily ignores the fact that "*in each case*" and particularly in *this case* a different result is required.

The Board's refusal to recognize the significance and relevance of the differences among acute-care hospitals is particularly illogical and inconsistent in light of its reasons for exempting nursing homes from the impact of the bargaining unit rule. In the Second Notice of Proposed Rulemaking the Board concluded that there are "significant differences between the various types of nursing homes which affect staffing patterns and duties." NPR II, Fed. Reg. at 33928. As evidence in support of this conclusion the Board noted that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." *Id.* at 33927. This assertion simply is incorrect.

In support of its assertion the Board cited evidence that nursing home facilities range in size from ten to 500 patients. *Id.* As stated above, acute-care hospitals in Missouri vary to an even greater degree, from eighteen to 1,208 licensed beds. The Board also cited evidence concerning the differing levels of care among the three basic types of nursing home facilities: skilled nursing, intermediate care and residential care. *Id.* There are hospitals in Missouri, however, where the level of care varies to an even greater degree within one institution. One hospital in Kansas City provides care ranging from acute intensive

and emergency care to long term residential care, with several levels and types of care between the extremes.

If the Board's findings with respect to the nursing home industry are correct, its irrebuttable rule for the substantially more highly diverse and more rapidly changing hospital industry must be incorrect. The Board's rationale for excluding nursing homes from the coverage of the rule requires precisely the same finding when applied to acute-care hospitals.

The Board's reasoning concerning the applicability of the rule to facilities providing care to psychiatric and rehabilitation patients also is inconsistent. The rule does not apply to facilities that are primarily psychiatric or rehabilitation hospitals, but *does* apply to psychiatric or rehabilitation units within facilities that fit within the rule's definition of an acute-care hospital. Under this scheme, the employees working on one of the floors of a 100 bed psychiatric unit at a large metropolitan hospital would be subject to the rule's mandatory bargaining unit determinations but the employees working at a 100 bed psychiatric hospital would not.⁵ There is absolutely no rational basis on which to make such a distinction. The reasons offered by the Board in support of its decision to exclude psychiatric hospitals from the rule apply with equal force to psychiatric units within acute-care hospitals.⁶

⁵ Both situations are found among MHA's members.

⁶ Among the reasons offered by the Board were: "that unlike other acute care hospitals, psychiatric hospitals do not provide care for the physically ill," that "many professionals participate hands-on with patients," that "RNs' work is closely integrated with the work of clinical psychologists, counselors,

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B. The Board's Rule Is Arbitrary And Capricious, Especially As It Applies To Small And Rural Hospitals With Widely Divergent Operations.

Fixed NLRB rules establishing pre-ordained hospital bargaining units are arbitrary and capricious.⁷ What is even more alarming is that the Board would seek to apply its rule to rural hospitals, carving out eight separate units for these small community institutions. This will have a disastrous effect on the delivery of health care services.

The Board is wrong. All hospitals are not alike. The differences among hospitals are substantial with wide ranges in size, purpose, scope, function, operations and staff. It is clear that the Board ignored the record which is replete with evidence that hospitals are quite distinct from one another. It is disingenuous for the Board to take a contrary position when, since the inception of the health care amendments to the Labor Act, the Board itself has recognized these distinctions.⁸

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social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators" and "that there are more paraprofessionals (mental health workers)." NPR II, Fed. Reg. at 33930.

⁷ See Brief of American Hospital Association, Petitioner pp. 26-28.

⁸ In *Otis Hospital*, 219 NLRB 55 (1975) the Board stated: "... the conclusion we reach is acknowledgement that not all health care institutions may be exactly alike. That is, we feel, the first lesson learned from the recent debates [over the health care amendments]. Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice

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Moreover, the Board's rule simply will not foster stability and harmonious labor relations during these times of immense and turbulent changes in the health care industry.⁹ What is occurring now among Illinois rural hospitals is instructive of how our country's acute health care system is revolutionizing. Hospitals are closing. From 1983 to 1990, 23 Illinois hospitals closed: 39% of these were small and rural hospitals. Eight small rural hospitals closed in two years alone.¹⁰ Nineteen counties in rural Illinois were left with no community hospital facility to provide health care.

Both patient admissions and inpatient days have declined significantly for rural facilities, a drop of approximately 27% from 1983 to 1988. The decrease of inpatient services has been offset by an expanding demand for outpatient services, which has increased 29%

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or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself. When parties contest the emphasis to be given to such characteristics, we are, of necessity, the arbiter." See also, *St. Francis Hospital*, 271 NLRB 948, 953 n. 39 (1984) where the Board found "the diverse nature of today's healthcare industry precludes any generalization as to the appropriateness of any particular bargaining unit."

⁹ The extent to which the Board's rule is arbitrary is demonstrated by its summary dismissal of the revolutionary changes impacting the delivery of healthcare. As noted *supra* p. 4, note 1, in NPR II, 53 Fed. Reg. at 33932, the Board cavalierly dismissed as "merely minor differences" the revolutionary changes and diversity in hospital operations.

¹⁰ The statistical information provided by Illinois health-care facilities and cited herein appears in *Trends, Small, Rural and Public Hospitals in Illinois: A Six Year Perspective, 1983-1988*, a 1990 publication of the Illinois Hospital Association.

over the same period. Not surprisingly, the statewide hospital bed occupancy rate dropped from 70% in 1984 to less than 63% in 1988. Rural hospital occupancy is dramatically lower. Rural hospitals under 100 beds had occupancy rates averaging between 42.7% and 47.3% in 1988. In 1985, the average number of patients hospitalized on any given day was approximately the same as those treated on an outpatient basis. Yet by 1988, the number of outpatients exceeded the number of inpatients by an average of nearly 2,800 each day for small rural hospitals. This ratio continues to grow and affects the nature and situs of operations, services and the staffing by occupational group.¹¹

By the year 2000 only 30% of healthcare will be delivered as inpatient care in hospitals; 45% will be ambulatory care; and 25% will be home care Also, there will not be full fledged hospitals anymore. . . . Instead there will be super 'tertiary advanced technology centers', community care centers, and ambulatory centers or *hospitals without beds*.¹² (emphasis added)

The revolution will bring about dramatic changes in staffing, particularly at small and rural hospitals. From 1984 to 1988 Illinois rural hospitals saw a 7% reduction in full-time equivalent personnel. Some of the occupational

¹¹ See "Outpatient Care: A Nationwide Revolution," *Hospitals Magazine* 28 (August 5, 1990). The Board's rule completely fails to acknowledge, much less deal with, this health care revolution.

¹² Address by Mark Howard, chief executive officer Intermountain Hospitals, Salt Lake City, Utah, to the 26th annual meeting and conference of the American Society for Healthcare Human Resources Administrators, July 18, 1990, Orlando, Florida. 4 *Labor Relations Week*, 728 (August 1, 1990).

groupings carved out by the Board's rule have experienced even larger reductions. For instance, employment of licensed practical nurses, the single largest occupational category in a technical employee bargaining unit, has declined by more than 27% in the past four years. Yet the Board would force technical units to be recognized wherever sought, regardless of changing circumstances.

Hospitals of all sizes and types have been plagued by financial problems which the Board chooses to ignore. The annual rate of increase in expenses has averaged between 3% and 5% each year. The amount of uncompensated charity care for rural hospitals has continued to grow. Recently, rural hospitals under 100 beds have reported large annual deficits on hospital operations averaging 2.7% to 4.6%. Expenses will grow if the Board's rule calling for multiple bargaining units is implemented.¹³

One Illinois hospital exemplifies how untenable the Board's fixed rule would be.¹⁴ In 1976, St. Joseph's

¹³ "In the hearing before the NLRB on rulemaking, there was substantial evidence presented as to the problems caused and costs incurred by multiple bargaining units in health care institutions. Direct costs associated with one round of bargaining for six units were over \$250,000. It was projected that negotiating one round of eight separate contracts would result in costs approaching \$360,000. It is a wonder therefore, that the NLRB has chosen to saddle this industry with costly, repetitive, and largely duplicative negotiations as a result of its proposed rules.", Stickler, "Union Organizing Will Be Divisive and Costly," *Hospitals Magazine*, 68 (July 5, 1990).

¹⁴ One must look to this sort of example to see the impact of rulemaking because there is no significant history of collective bargaining among employees in 220 Illinois hospitals.

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Hospital, Highland, Illinois, was a 144-bed facility providing a full range of acute-care services. It had a total work force of 370 employees. Today St. Joseph's operates and staffs a single facility which houses a 40 bed acute-care hospital and a 30 bed skilled nursing facility. Many of the services provided in 1976 have been scaled down, contracted out or no longer are provided. In 1990, the average daily inpatient census is only 19 acute-care hospital patients, and 28 skilled nursing care patients.¹⁵ Moreover, the staff has been reduced from 370 hospital employees to 208 hospital and skilled nursing full-time equivalent personnel for the combined operation.

The hospital, which had a surplus from hospital operations in the 1970's, has had a deficit from operations in 10 of the past 11 years. Without outpatient revenue, the hospital would cease to be financially viable.

Assuming, *arguendo*, that the Seventh Circuit decision is denied review, the Board's rule would potentially result in six separate units, with six separate contracts to

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Thus, more than 92% of all Illinois hospital workers are non-union. Fewer than 2% of all registered nurses are members of a labor organization. Moreover, since the 1974 Health Care Amendments to the Taft-Hartley Act, RNs have been organized in only 3 units that include all other professional employees. See, *Testimony On Appropriate Bargaining Units In The Health Care Industry Before the NLRB*, September 1, 1987, as attachment 10 to the American Hospital Association comments on proposed rule "Collective Bargaining Units In The Health Care Industry" (29 CFR Part. 103), December 17, 1987.

¹⁵ The average length of stay of acute-care hospital patients is approximately 7.0 days. The average length of stay of skilled nursing patients is 47 days.

be negotiated and administered at St. Joseph's Hospital.¹⁶ The costs of negotiating and administering six different contracts would threaten the very existence of this small rural hospital. Hundreds of small, rural hospitals located throughout the country could suffer similar experiences and potentially disastrous results from the Board's bargaining unit rule.

Missouri and Illinois truly are microcosms of the health care industry. The members of the MHA and IHA do not fit some artificial hospital profile which fills the Board's need to categorize hospitals and their employees in neat pigeonholes and thereby avoid its statutory obligation to make individual findings in each case. They are real hospitals serving real people in the rural areas, small towns, suburbs and urban centers of incredibly diverse states. They, their employees and their organizational structures reflect that diversity and it is arbitrary and capricious for the Board to ignore reality in favor of some artificial norm which exists only in the mind of the Board.

II. THE RULE WILL RESULT IN A PROLIFERATION OF BARGAINING UNITS IN ACUTE-CARE HOSPITALS.

In 1974, when Congress amended the Labor Act to include not-for-profit hospitals, it included in its Committee reports the following admonition:

Due consideration should be given by the Board to preventing proliferation of bargaining

¹⁶ There are no employed physicians nor security guards who would constitute the seventh and eighth units. The size of the units would range from six business office clericals and eight maintenance and grounds employees at the low end to a unit of forty-five service employees in the largest unit.

units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).

By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

As the District Court in this case recognized "[t]he stakes are higher when the Board makes bargaining unit determinations in the health care field, fragmentation of the workforce is more likely and of greater concern when patient care is at issue." Petitioner's Appendix ("Pet. App.") at 36a. The District Court concluded that, in promulgating a rule which "designates an absolute number of appropriate units and mandates a particular division of the workforce," the Board was not responsive to the express concerns of Congress. Pet. App. at 41a-42a. The District Court based its conclusion, in part, on the fact that the rule requires the "automatic fragmentation of the workforce into eight units, without regards to the nature and extent of the health services rendered or the dynamics of a particular health care institution." Pet. App. at 37a (emphasis in original).

The MHA believes that this conclusion also is supported by the history of organizational activity that has occurred in Missouri. Labor organizations in this state have not hesitated to seek to represent broader units of employees than those that will be mandated by the rule.

For example, in a 1986 election at Spelman Memorial Hospital (Case No. 17-RC-9796), the International Brotherhood of Teamsters sought two units, one of professional employees and one of nonprofessional employees. In an earlier election at the same institution in 1980, Local 96 of the Service Employees International Union (Case No. 17-RC-8917) sought the same two units.

In another 1980 case, the Board conducted an election in two units sought by Local 50 of the Service Employees International Union, one of all ambulance department employees and the other of all other employees employed at Wright Memorial Hospital in Trenton, Missouri. In that case the finding of a separate unit of ambulance drivers and emergency medical technicians was a result of a unique organizational structure that made such a unit appropriate. In the same case the Board concluded, contrary to what might normally be found, that all registered nurses in the hospital actually functioned as Section 2(11) supervisors and, therefore, were not employees for purposes of organization under the Labor Act. *Wright Memorial Hosp.*, 255 NLRB 1319 (1981). After taking extensive testimony in that case, the Board itself demonstrated why presumptions and rules are not appropriate in this industry. If the Board, in that instance, had chosen to assume that nurses are nurses and hospitals are hospitals, it never would have taken cognizance of the unique organizational structure of the emergency services and the unique responsibilities of the registered nurses at Wright Memorial Hospital. Such a failure would have altered substantially the outcome of the case.

III. THE VALIDITY OF THE RULE IS OF GREAT SIGNIFICANCE TO HOSPITALS IN MISSOURI, ILLINOIS AND ACROSS THE COUNTRY.

The bargaining unit rule promulgated by the Board and upheld by the court of appeals for the Seventh Circuit applies to the vast majority of acute-care hospitals in Missouri, Illinois and across the nation.¹⁷ The validity of the rule is of importance not only to those hospitals within the jurisdiction of the Seventh Circuit, but to the health care industry nationwide. The MHA and IHA believe that this issue, involving the interpretation of a federal statute, is of sufficient national importance to warrant consideration by this Court.

Within the Seventh Circuit, this Court's consideration of the validity of the bargaining unit rule is essential to remedy the errors committed by the Board and the Court of Appeals.

Outside the Seventh Circuit, the validity of the bargaining unit rule will be at issue in every acute-care hospital bargaining unit determination made by the Board. The opportunity for hospitals to raise the issue of the validity of the rule in a specific case, however, will not occur before a great deal of time and resources have been expended by the Board, hospital, union and employees involved. Although a hospital may object to the Board's application of the bargaining unit rule when a unit is certified, the hospital does not have an opportunity to challenge the validity of the rule or the bargaining unit in court until after a union has been elected. If the hospital believes the bargaining unit mandated by the

¹⁷ Governmental hospitals are the only acute-care hospitals that are excluded from the Labor Act and the rule.

rule is inappropriate it may refuse to bargain with that unit and defend its position in its own Court of Appeals. Only then may the hospital challenge the validity of the rule which served as the basis for the union election. These hospital-by-hospital challenges likely will result in a conflict among the courts of appeals which this Court ultimately will be asked to resolve.

In addition, the potential exists for a multiplicity of lawsuits similar to the one filed by the AHA seeking injunctive and declaratory relief from the application of the Board's rule. Absent review by this Court, hospitals and hospital associations outside the Seventh Circuit may choose to challenge the validity of the rule as promulgated rather than wait for a specific application of the rule by the Board. These challenges also could result in a conflict among the circuits and further petitions for review by this Court.

Hospital-by-hospital and state-by-state challenges to the validity of the bargaining unit rule will place an extreme burden on the already overburdened hospital industry. Hospitals nationwide should not be forced to choose between acquiescing to an invalid rule because it is too costly to challenge and expending scarce resources on litigation. This Court can eliminate this Hobson's choice by granting the petition for certiorari and resolving this issue.

CONCLUSION

For the forgoing reasons, and those stated in the brief of petitioner, the MHA and IHA respectfully request that the American Hospital Association's petition for a writ of certiorari be granted.

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In the Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
PETITIONER

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
RESPONDENTS

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

**BRIEF AMICUS CURIAE OF WILLIAM BEAUMONT
HOSPITAL, HENRY FORD HOSPITAL, ST. JOHN
HOSPITAL AND MEDICAL CENTER, AND
THE MICHIGAN HOSPITAL ASSOCIATION
IN SUPPORT OF THE PETITIONER**

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**BRIEF AMICUS CURIAE OF WILLIAM BEAUMONT
HOSPITAL, HENRY FORD HOSPITAL, ST. JOHN
HOSPITAL AND MEDICAL CENTER, AND
THE MICHIGAN HOSPITAL ASSOCIATION
IN SUPPORT OF THE PETITIONER**

William Beaumont Hospital, Henry Ford Hospital, St. John Hospital and Medical Center, and the Michigan Hospital Association respectfully submit this *amicus curiae* brief in support of the American Hospital Association's petition for a writ of certiorari.¹

INTEREST OF THE AMICI CURIAE

The three individual hospitals submitting this *amicus curiae* brief — William Beaumont Hospital, Henry Ford Hospital, and St. John Hospital and Medical Center — are among the largest and most diversified acute care hospitals in the state of Michigan.

¹ The written consent of each of the parties to the filing of this brief has been filed with the Court.

Located in metropolitan Detroit, these three hospitals account for nearly 20 percent of all hospital admissions in southeastern Michigan. They collectively employ nearly 20,000 individuals at their primary hospital locations and at numerous medical centers and satellite facilities throughout the Detroit metropolitan area. With only the remotest of exception (largely involving guards), the workforces of these hospitals have not been organized by labor unions.

The fourth *amicus curiae*, the Michigan Hospital Association, is a voluntary non-profit membership corporation consisting of 209 organizations that provide critical health care services to the 9,000,000 citizens of Michigan. Member facilities range in size from the 15-bed 379th Strategic Hospital at the Wurtsmith Air Force Base to the 960-bed Henry Ford Hospital in downtown Detroit. Approximately one-half of the Association's members are small institutions having fewer than 100 beds; most of these are located in rural areas of Michigan where they serve as the primary providers of health care services in their communities. The other half of the Association's members serve the various urban areas of the state.

The three individual hospitals submitting this *amicus* brief, and a substantial number of the Association's other members, are deeply affected by the National Labor Relations Board's promulgation through rulemaking of a virtually *conclusive presumption* that eight collective bargaining units are appropriate for them and for all other acute care hospitals throughout the United States. The Board's rule is predicated on a fundamentally mistaken "empirical" premise: that all acute care hospitals are the same, as if fashioned from a single cookie cutter, regardless of their substantial differences in mission, location, size, organizational structure, staffing patterns, and the like. The Board's rule purports to treat all hospitals according to a least-common-denominator model without any pretense of giving consideration to the unique characteristics of each hospital — uniquenesses that are illustrated by the hospitals and Association members submitting this brief.

In view of the immense and disruptive potential for case-by-case litigation over the validity of the Board's rule, in Michigan and elsewhere, *amici curiae* respectfully urge that the Court grant the American Hospital Association's petition for a writ of certiorari, and declare that the Board's rule universally prescribing eight separate units for every acute care hospital was improperly promulgated and cannot be applied.

INTRODUCTION AND SUMMARY OF ARGUMENT

At first blush the Board's rule prescribing eight units for all acute care hospitals may appear to be an efficient and sensible way of creating predictability and minimizing litigation in this important field. It becomes clear upon closer scrutiny, however, that the Board's rule has severe defects warranting this Court's review now.

Perhaps most remarkably, the Board's rule flies in the face of the National Labor Relations Act's own language, which in Section 9(b) requires that bargaining unit determinations be made "in each case." The explanations given by the Board for effectively erasing this language from the Act do not survive analysis. The Act clearly requires the Board to conduct case-by-case adjudications to determine appropriate bargaining units in this and every other industry — thereby taking into account the unique characteristics of particular employers and their employee groupings.

The Board's rule also disregards the congressional admonition against proliferation of bargaining units in the health care industry. While the Board suggests that the eight units prescribed for acute care hospitals in the rule is not *that many* more than the three-unit statutory minimum, or the six-unit configuration the Board proposed at the outset of its rulemaking proceeding, the addition of even one or two more bargaining units — *and these are the units likely to become organized* — causes undue proliferation and the potential for all of the disruptive consequences feared by Congress when the Act was amended in 1974. The

Board is seeking to accomplish through rulemaking the very same result that the courts have repeatedly struck down in adjudicated cases as violative of the congressional admonition. This warrants review by this Court.

The Board's rule is also arbitrary and capricious. It presumes that alleged "empirical" evidence *generally* applicable to the hospital industry may legally surmount *particularized* evidence concerning the structure and operations of a specific hospital. As the Board's own prior adjudicatory decisions show, there are wide variations within this rapidly evolving industry that require flexibility in unit determinations. The rule conclusively prohibits this flexibility.

Underlying the Board's rulemaking is its unwarranted belief that Congress was simply wrong when it expressed concern in 1974 over work stoppages, jurisdictional disputes, whipsawing, and leapfrogging in the health care industry. Those were then, and are still, real and legitimate concerns for individual hospitals and for the industry as a whole. The Board has effectively overruled Congress' concern. The American Hospital Association's petition should be granted.

ARGUMENT

I. Section 9(b)'s "In Each Case" Requirement Mandates Individual Bargaining Unit Determinations

In its First and Second Notices of Proposed Rulemaking, and in promulgating its Final Rule, the Board considered but rejected the argument raised by commentators that it is improper for the Board affirmatively to prescribe *substantive bargaining units* for a class of employers through rulemaking. NPR I, 52 Fed.Reg. 25144-25145; NPR II, 53 Fed.Reg. 33901; Final Rule, 54 Fed.Reg. 16338. The Board acknowledged that this is the Board's "first venture in major, substantive rulemaking," *id.* at 16339, inasmuch as its prior rulemaking had involved non-substantive procedural or jurisdictional matters applicable to cases generally.

One Board Member, Wilford W. Johansen, dissented from the Board majority's conclusion that Section 9(b)'s "in each case" requirement permits this type of substantive bargaining unit rulemaking. NPR II, 53 Fed.Reg. 33935; 54 Fed.Reg. 16347. Eight years earlier, a differently composed Board had adopted what has now apparently become the dissenting view. In *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), the Board held that the "in each case" requirement of Section 9(b) precluded any *per se* approach to unit determinations. Two years later, in *St. Francis Hospital I*, 265 NLRB 1025, 1028 (1982), the Board reaffirmed the view that Section 9(b)'s "in each case" requirement mandated case-by-case adjudication; and it did so again in *St. Francis Hospital II*, 271 NLRB 948, 954 (1984) ("[N]o unit is *per se* appropriate and . . . separate representation must be justified upon each factual record . . .").

What rational explanation has the Board presented for its abruptly changed view of the Act's "in each case" requirement? The Board has essentially stated three reasons, but none withstands scrutiny.

First, the Board majority has extensively relied on language from Kenneth Culp Davis' *Administrative Law Text* 145 (3d ed. 1972) that Section 9(b)'s "in each case" requirement

does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents.

NPR I, 52 Fed.Reg. 25144; NPR II, 53 Fed.Reg. 33901; see also Final Rule, 54 Fed.Reg. 16338.² Beyond that, the Board majority notes that "[i]t has long been the Board's practice to formulate 'rules' to guide it in representation matters," including contract

² Davis' *Administrative Law Text* is a law student hornbook. *Id.* at III. The quoted comment concerning the Act's "in each case" requirement does not appear in Davis' subsequent treatises, which more broadly discuss the Board's rulemaking power. See, e.g., 2 Davis, *Administrative Law Treatise* §7:25 (1979).

bar rules, voter eligibility list requirements, and the like. NPR II, 53 Fed.Reg. 33901.

The shortcoming in the Board majority's reasoning is that Davis' comment was not referring to *substantive rules affirmatively prescribing universally appropriate bargaining units for an entire industry*. Davis was referring instead to "classifying problems, . . . developing rules or principles, . . . or relying on precedent cases which establish narrow or broad propositions." *Administrative Law Text, supra*. What the Board has now done is a far cry from establishing those types of general rules (exemplified by the contract bar rule and voting eligibility list requirement), which merely define the perimeters within which representation questions will be determined. It is a remarkable stretch of logic to suggest, as the Board majority does, that Davis' comment or the Board's own prior rulemaking can legitimize the instant rule. The dissenting Board member properly rejected this justification.

The Board secondly contends that this Court's decision in *Heckler v. Campbell*, 461 U.S. 458 (1983), a case addressing the Social Security Administration's "grid" method of determining disability benefit entitlements, supports the Board's substantive unit determinations for the hospital industry. But *Heckler* provides no support at all, and indeed counsels the contrary. This Court there held that an "agency may rely on its rulemaking authority to determine issues that do *not* require case-by-case consideration." *Id.* at 467 (emphasis added). Here the Board is obligated by Section 9(b) of the Act to make a unit determination "in each case." What is more, *Heckler* held that the Secretary was required to make "findings on the basis of evidence adduced at a hearing" with regard to a claimant's individual abilities and qualifications, and that the Secretary could utilize rulemaking *only* for determining "an issue that is not unique to each claimant." *Id.* at 467-468. It is this portion of the *Heckler* decision that applies here.

There may be historical or statistical information regarding hospitals — analogous to the national employment and economic

information in *Heckler* — that the Board could properly assimilate into a representation case's hearing record through rulemaking. But the existence *vel non* of distinct and appropriate bargaining units in a particular hospital is unquestionably an issue that is "unique" to that hospital.

Third, the Board asserts that, notwithstanding its eight-unit rule, an acute care hospital will always be permitted a hearing in a representation case and that a hospital can in any event take advantage of the "extraordinary circumstances" exception if its own unique characteristics do not fit the mold of the rule. Final Rule, 54 Fed.Reg. 16338 and n.2. These offerings by the Board ring hollow. If the Board was serious about this, it would have crafted a rule containing *rebuttable*, rather than virtually *irrebuttable*, presumptions of appropriate units; the Board rejected that option as unnecessary and inefficient. NPR I, 52 Fed.Reg. 25145; Final Rule, 54 Fed.Reg. 16338-16339. It could not be clearer that the Board does not want individualized hearings on hospital bargaining units. Only evidence concerning ancillary issues — not related to appropriate units — would be allowed in a representation hearing. Final Rule, 54 Fed.Reg. 16338. And the "extraordinary circumstances" exception has been repeatedly described by the Board as so narrow as to banish it from existence. NPR I, 52 Fed.Reg. 25145; NPR II, 53 Fed.Reg. 33932. The Board's catalog of factual "variations in acute care hospitals" that will *not* be considered under the "extraordinary circumstances" exception (*id.*) is so comprehensive as to render it meaningless. That exception surely cannot be held out by the Board as a cure-all for the rule's denial of due process and its disregard of Section 9(b)'s "in each case" requirement.

There can be no doubt that the purpose and effect of the Board's rule mandating eight bargaining units in all acute care hospitals is to eliminate, once and for all, unit determinations "in each case." That result not only runs afoul of Section 9(b), but is

at odds with decisions of this Court.³ The Seventh Circuit's decision upholding the Board's rule is also in conflict with decisions of other Courts of Appeals that have previously found *per se* approaches by the Board to unit determinations violative of Section 9(b)'s "in each case" requirement.⁴

II. The Board's Rule Is Precluded By The Congressional Admonition Against Proliferation Of Bargaining Units In The Health Care Industry

Much debate has focused over the past 15 years on the weight and meaning to be ascribed to the admonition contained in the House and Senate Reports to the Health Care Amendments Act of 1974 that the Board give "[d]ue consideration ... to preventing proliferation of bargaining units in the health care industry." S.Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R.Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). The Seventh Circuit's decision below, holding the congressional admonition entitled only to "respectful consideration," is squarely in conflict with decisions of other Courts of Appeals which have given the admonition controlling weight in rejecting Board unit determinations.⁵ This conflict warrants a grant of certiorari in this case.

³ See *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947); *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

⁴ See, e.g., *Big Y Foods, Inc. v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981); *Long Island College Hospital v. NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), *cert. denied*, 435 U.S. 896 (1978); *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 638 (2d Cir. 1983); *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 360 (3d Cir. 1976); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979).

⁵ See *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, *supra*, 699 F.2d 626, 638 (2d Cir. 1983); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981). At the opposite end of the spectrum from these decisions is the D.C. Circuit's decision in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697, 712 (D.C. Cir. 1987), which

When the Board initially undertook hospital unit determinations after the 1974 amendments, it generally found eight units appropriate — just as the present rule does. This formulation met with little success in the Courts of Appeals,⁶ primarily for the reason that those units failed to comport with the congressional admonition. The Board then reconsidered its overall approach to hospital units. In *St. Francis Hospital II*, 271 NLRB 948 (1984), the Board formulated a new standard, moving from a "community of interests" test that generally produced eight appropriate units in a hospital to a "disparity of interests" test that generally produced five units, stating:

With the benefit of many years of thoughtful and often conflicting analyses among the Board members, courts of appeals, and legal commentators, we have formulated a revised health care employee unit approach which we believe will fulfill our dual obligations of adhering to the legislative intent behind enactment of the 1974 health care amendments to the Act and guaranteeing the representational interests of health care employees.

271 NLRB at 948 (footnote omitted).

"After careful and thorough consideration," the Board continued in *St. Francis II*, its Members were "persuaded" that the prior approach was "contrary to the intent of Congress" and that "the adoption of a disparity-of-interests tests can best effectuate our statutory obligations in health care unit determinations." *Id.* at 950. Furthermore, "Congress clearly intended that, in determining appropriate units in the health care area, the Board should apply a stricter standard than its traditional community-of-interest analysis." *Id.* at 951.

found the congressional admonition essentially meaningless because it was never incorporated into the Act itself.

⁶ See, e.g., *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

The eight-unit formulation found in the Board's rule today is no different than the eight-unit formulation (utilized prior to *St. Francis II*) which had been rejected by many Courts of Appeals as inconsistent with the congressional admonition. The only notable difference is that the Board's new rule purports to be based on "empirical" evidence regarding the health care industry as a whole, rather than on an evidentiary record compiled in a single adjudicatory proceeding; in addition, the rule purports to govern an entire industry rather than a single hospital.

Thus, there is no dispute that the Board is attempting to accomplish through "empirical" rulemaking exactly what the courts have forbidden as violative of the congressional admonition — an eight-unit configuration for hospitals. Anomalously, the Board has taken this across-the-board approach in the *only* industry for which Congress expressed concern that the Board act with special care in determining units. No other class of employers has been singled out by the Board for the mandatory establishment of bargaining units without any regard to the configuration of their particular operations.⁷

In summary, in conjunction with Section 9(b)'s "in each case" requirement, the congressional admonition mandates that the Board conduct case-by-case adjudications to determine appropriate bargaining units in the health care industry — no less than it does in all other industries — and in so doing to avoid unit proliferation at each hospital. The Board's rule is the very

⁷ The Board has repeatedly emphasized throughout the rulemaking proceedings that, even though its rule provides for eight separate bargaining units, it is unusual that a hospital would actually be organized to this extent by labor unions. NPR II, 53 Fed.Reg. 33908, 33909, 33910, 33923, 33933, 33934; Final Rule, 54 Fed.Reg. 16346. This misses the relevant point, however, because the Board's rule makes it an inevitability that there would be eight separate units in the event unions sought to organize them. And the advance subdividing of the work force would facilitate such organizing. It is thus illogical for the Board to suggest that the *presently* incomplete state of union organization mitigates the violence its rule does to the congressional admonition against proliferation.

Ironically, the Board states in NPR II that proliferation is relieved by the fact that guard units are "rarely sought" (53 Fed.Reg. 33934). It is precisely those units that have been organized at the three hospitals submitting this brief.

antithesis of this mandate, because it prescribes that every acute care hospital will have eight bargaining units.⁸ The Seventh Circuit's decision upholding the Board's rule notwithstanding the congressional admonition merits review by this Court.

III. The Board's Rule Is Arbitrary And Capricious

The Board has acknowledged that it engaged in this rulemaking because the courts rejected its prior approach to health care bargaining units:

Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.

NPR I, 52 Fed.Reg. 25143.⁹

⁸ The Board itself increased the number of mandatory units at acute care hospitals from six in NPR I (52 Fed.Reg. 25149) to eight in NPR II (53 Fed.Reg. 33934), conclusorily stating in NPR II that the addition of these two units (skilled maintenance and business office clericals) did not produce a proliferation of bargaining units (53 Fed.Reg. 33923, 33926). The Board noted that 23 conceivable bargaining units (and perhaps an equal number of additional units) could *theoretically* arise in any single establishment, and that it is in any event "unlikely that all eight potential appropriate units will occur in any given hospital" (54 Fed.Reg. 16346). Needless to say, these statistics and predictions are of no solace to hospitals for whom the proliferation of even one or two additional units can have major consequence.

⁹ The Board initiated the rulemaking process in apparent reaction to the D.C. Circuit's decision in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. 1987), holding (as no other Circuit had) that the Board had *improperly* concluded that the congressional admonition mandated a "disparity of interests" test for hospital bargaining units. The D.C. Circuit also held, however, that the Board possessed discretion to adopt a "disparity of interests" test, and expressed no view as to what test the Board should embrace in the exercise of its discretion. *Id.* at 699, 708 n.37, 711-712 n.65. See also *St. Vincent Hospital*, 285 NLRB 365, 367 (1987). Nothing precluded the Board from continuing to adhere to the "disparity of interests" test notwithstanding the D.C. Circuit's decision in *IBEW v. NLRB*, as the Board chose to do in *St. Vincent Hospital*.

But why should a result achieved through rulemaking succeed where the identical result achieved through adjudication failed? The Board's rule rests on the notion that "empirical" evidence concerning the hospital industry *generally* can legitimize a result (eight *per se* appropriate units) that has been and would be struck down in an adjudicatory proceeding.

The fundamental problem with the Board's approach is highlighted by this Court's decision in *Heckler v. Campbell*, *supra*. Just as individual Social Security disability claimants' qualifications required individual hearings as to their unique facts in *Heckler*, acute care hospitals are also sufficiently unique in mission, location, size, organizational structure, staffing patterns, and the like, to require individualized hearings concerning appropriate bargaining units. Individual hospitals are not fungible, nor are they mere statistics. It is wrong for the Board to declare by rule or fiat that they are.

This error pervades NPR II. It repeatedly acknowledges that the Board has based its rule on generalized least-common-denominator evidence and has purposefully eschewed deviations from the general pattern at particular hospitals. A single but dramatic example concerns the use by some hospitals of special multi-disciplinary teams. The Board emphasizes that "the *weight* of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals," and that "*fewer than half*" of the hospitals studied used special multi-disciplinary teams while "[s]ome hospitals do not utilize the team concept at all." NPR II, 53 Fed.Reg. 33907 (emphasis added). What the Board overlooks is that many hospitals do use special multi-disciplinary teams, in a fashion that removes them from the mainstream and warrants consideration of a different bargaining unit structure. There are many other examples in NPR II of individual variations being dismissed by the Board in favor of the "typical," "normal," or "general"

characteristics of hospitals. It is nevertheless indisputable that some hospitals do not fit that mold.¹⁰

The arbitrariness of the Board's rule can also be seen in its treatment of *its own prior decisions* holding inappropriate, on the unique facts presented in those adjudications, the very bargaining units its rule would today declare universally appropriate. In *St. Vincent Hospital*, 285 NLRB 365 (1987), the Board held on the basis of an adjudicatory record that a separate registered nurses unit was inappropriate at that hospital because of the hospital's particular organizational structure, personnel policies, integration of employees, and the like. The Board's rule now decrees that a separate registered nurses unit is universally appropriate. The Board has sought to harmonize this inconsistency as follows:

Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations. . . . [W]ere we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

NPR II, 53 Fed.Reg. 33916.

The Board has used the same sleight-of-hand for a separate skilled maintenance unit, which the Board had held inappropriate on the factual record in *St. Francis Hospital III*, 286 NLRB 1305 (1987), see NPR II, 53 Fed.Reg. 33923; and a separate business office clerical unit, which it had held inappropriate on the factual record in *Baker Hospital*, 279 NLRB 308 (1986), see NPR II, 52 Fed.Reg. 33926. Regardless of a particular hospital's configuration of these employee groupings, skilled maintenance and business office clerical units are now declared universally appropriate.

¹⁰ That the Board will permit non-conforming stipulations (NPR II, 53 Fed.Reg. 33931) also demonstrates that some hospitals are sufficiently far from the "normal" or "typical" configuration as to warrant different treatment.

The rule's arbitrariness is further shown by its failure to allow for full evidentiary consideration of the unique characteristics of large and diversified acute care hospitals (such as those submitting this *amicus* brief) and the ramifications of those characteristics on unit determinations. Many large urban hospitals today operate through an integrated network of dispersed medical centers and other facilities that comprise a single hospital system. Indeed, some have several geographically separate "campuses," but may well share employees, administrative services, and patients. Depending on a particular hospital system's organization, various locations may, or may not, have employees with identical interests, working conditions, supervision, and the like. It would be arbitrary indeed for a rule to presume irrebuttably (as the Board's rule evidently does) that such an organizational and geographic structure must be disregarded, and that only contiguous facilities be considered, in assigning the eight bargaining units decreed by the rule. See NPR II, 53 Fed.Reg. 33932.

By like token, the Board's rule allows no differentiation for the uniqueness of the many smaller and rural hospitals that constitute approximately one-half of the Michigan Hospital Association's membership. Those smaller and rural hospitals have dramatically different organizational structures and staffing patterns to reflect the lesser size and complexity of the institution. But the Board's rule treats all acute care hospitals as though they are the same — whether they have 8,000 employees or just 80. The rule effectively denies a hospital's right to adduce evidence regarding its own uniqueness or differentiation from the Board's perceived pattern.

As a final matter, the Board's second-guessing of Congress' concern in 1974 about proliferation of units in the health care industry is itself evidence of arbitrariness. The Board suggests in its Final Rule that Congress' articulated fear of work stoppages, jurisdictional disputes, wage whipsawing, and leapfrogging in the health care industry was unfounded because "multiple units have not been shown to cause an unusual number of work stoppages, nor that have they been shown to have caused jurisdictional

disputes, wage whipsawing, or leapfrogging. . . . [T]here were virtually none of the disruptive consequences which concerned Congress during the 1974 debates" (54 Fed.Reg. 16346). The Board's logic misses the point that the courts have not tolerated proliferation of bargaining units in the hospital industry. The courts have rejected the eight units prescribed by the Board in its early decisions. These are the same eight units as those now prescribed in the rule. The evils feared by Congress have not been permitted to occur, as well they might if the Board's rule were now allowed to take effect.

CONCLUSION

The validity or invalidity of the Board's rule should be resolved now, so that much litigation may be avoided. The American Hospital Association's petition for a writ of certiorari should be granted.

Respectfully submitted,

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Dated: September 1990

NOV 23 1990

JOSEPH F. SPANIOLO, JR.
CLERK

In The
Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United States
Court Of Appeals For The Seventh Circuit

JOINT APPENDIX

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Petition For Certiorari Filed July 10, 1990
Certiorari Granted October 9, 1990

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The opinion of the United States Court of Appeals for the Seventh Circuit (Pet. App. 1a-16a), and the Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois (Pet. App. 17a-42a) are included in the Appendix to the Petition for Writ of Certiorari.

American Hospital Ass'n v. NLRB

Docket Entries

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS,
NO. 89-C-3279.

Filed 04/21/89: Complaint

Minute order of
05/22/89: The plaintiff's motion for a preliminary injunction is granted.

Minute order of
07/25/89: The plaintiff's motion for a permanent injunction is granted. The defendant's motion for summary judgment is denied. The petition of the AFL-CIO and the American Nurses Association to intervene is granted.

Filed 07/28/89: Defendant-Intervenors NOTICE OF APPEAL re: order dated 07/25/89 (\$105.00 paid).

Filed 07/31/89: Defendant's NOTICE OF APPEAL re: order dated 07/25/89 (NO FEE REQUIRED) NLRB.

Filed 08/01/89: Defendant's-Intervenors AFL-CIO NOTICE OF APPEAL re: order dated 07/25/89 (\$105.00 paid).

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT,
NOS. 89-2604, 89-2605, 89-2622

8/1/89 U.S. civil case docketed [89-2604 & 89-2605].

8/3/89 U.S. civil case docketed [89-2622].

8/9/89 ORDER: The court orders these appeals CONSOLIDATED for purposes of briefing and disposition: [89-2604, 89-2605, 89-2622].

4/11/90 ORDER: Final judgment, REVERSED.

5/2/90 ORDER issued GRANTING motion to stay mandate.

5/11/90 ORDER issued DENYING motion for reconsideration.

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board.

ACTION: Notice of proposed rulemaking and notice of hearing.

SUMMARY: In order to facilitate the election process, the National Labor Relations Board proposes to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities. The Board has resolved to utilize notice-and-comment rulemaking rather than be presented with continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case. Interested parties may submit oral testimony in connection with the proposed rules.

DATES: Comments must be received on or before October 30, 1987.

Hearings are scheduled as follows: August 17, 1987, Washington, DC, 9:00 a.m.; August 31, 1987, Chicago, Illinois; September 14, 1987, San Francisco, California.

Persons wishing to present oral testimony at any one of the specified locations shall call or write no later than July 24, 1987.

ADDRESSES: Comments should be sent to: Office of the Executive Secretary, 1717 Pennsylvania Avenue, NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

The hearings will be conducted at the following locations:

(1) *Washington, DC* - The Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue, NW., Washington, DC 20570.

(2) *Chicago, Illinois* - Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353-7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California* - Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's San Francisco Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995-5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the office of the Executive Secretary, 1717 Pennsylvania Ave., NW., Washington, DC 20570, telephone number (202) 254-9430.

FOR FURTHER INFORMATION CONTACT: John C. Truesdale, Executive Secretary. Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION:

I. Background

Since 1974, when Congress extended the protection of the National Labor Relations Act to nonprofit hospitals, the Board has taken literally hundreds of thousands of pages of testimony in a myriad of litigated cases regarding particular circumstances at various health care facilities. Nonetheless, to this day there is no one, generally phrased test for determining appropriate units in this industry that has met with success in the various circuit courts of appeal, and, unfortunately, parties have no clear guidance as to what units the Board and courts will ultimately find appropriate.

At the outset, in a series of 1975 decisions, the Board found appropriate several specific types of units. For example, in *Mercy Hospitals of Sacramento*,¹ after noting the congressional admonition against "undue proliferation," the Board found appropriate a separate unit of registered nurses, finding that they possess "interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry." Thereafter, in *NLRB v. St. Francis Hospital of Lynwood*,² the Ninth Circuit rejected the *Mercy* doctrine, finding that the Board had set forth an unwarranted presumption of appropriateness in that adjudicative proceeding,³ and, further, that the Board had

¹ 217 NLRB 765, 767 (1975), enf. denied on other grounds 589 F.2d 968 (9th Cir. 1978) cert. denied 440 U.S. 910 (1979).

² 601 F.2d 404 (9th Cir. 1979).

³ Id. at 414-417.

improperly looked for a "community of interests" rather than a "disparity of interests."⁴ The Board's later *Newton-Wellesley Hospital* decision⁵ represented an explicit effort by the Board to address the Ninth Circuit's concerns in *St. Francis*, but subsequent decisions based on *Newton-Wellesley* met with no greater judicial acceptance.⁶ Finally, after a number of years of unsuccessfully advocating variations of the "community of interests" test with respect to registered nurses, the Board, in *North Arundel Hospital Assn.*⁷ and *Keokuk Area Hospital*,⁸ moved toward the Ninth Circuit's view and held that the disparity of interests test should be applied, having found in *St. Francis Hospital*⁹ that that test better met the standards desired by Congress and required by the courts. Yet, recently the D.C. Circuit has severely criticized *St. Francis II*,¹⁰ holding that the disparity test was not mandated by the legislative history, and strongly suggesting that some variation of the historically accepted community of

⁴ Id. at 418-419.

⁵ 250 NLRB 409 (1980).

⁶ See, e.g., *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982). See also *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980).

⁷ 279 NLRB No. 48 (Apr. 16, 1986).

⁸ 278 NLRB No. 33 (Jan. 27, 1986).

⁹ 271 NLRB 948 (1984) (*St. Francis II*).

¹⁰ *Electrical Workers IBEW Local 474 (St. Francis Hospital) v. NLRB* 814 F.2d 697 (D.C. Cir. 1987).

interests standard was required.¹¹ Similarly, the Second,¹² Eighth,¹³ and Eleventh Circuits,¹⁴ while acknowledging the necessity to restrict health care units, have directly or indirectly disagreed with the disparity of interests test.

In cases involving maintenance units, the Board's decisions have, likewise, not achieved judicial acceptance. Nor have Board Members among themselves always agreed on the proper test to apply. In the first lead case, *Shriners Hospitals for Crippled Children*,¹⁵ the Board was split three ways: two members found the requested unit of stationary engineers did not possess a "community of interest sufficiently separate and distinct" to warrant a separate unit; a third member concurred generally; and two other members found the requested unit appropriate. Thereafter, in an attempt to clarify the law in this area, the Board held a special oral argument. Consensus was not achieved. In one case, a majority of the Board found a separate maintenance unit inappropriate;¹⁶ in another, though finding a unit of stationary engineers to

¹¹ As concurring Judge Buckley observed, the majority technically left open the possibility the Board was entitled to switch from the community of interests standard, but did so in "ominous tones," thereby rendering an "advisory opinion" on that matter. (Id. at 718).

¹² *Masonic Hall v. NLRB*, 699 F.2d 626 (1983).

¹³ *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848, 850 (1983).

¹⁴ *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1539 at fn. 4 (1984).

¹⁵ 217 NLRB 806 (1975).

¹⁶ *Jewish Hospital of Cincinnati*, 223 NLRB 614 (1976).

be appropriate, the Board relied on four different rationales.¹⁷ The Board's treatment of this area was criticized by the Third Circuit, which held that in these cases the community of interests standard intended by Congress was a nontraditional one, and that the Board had not struck the proper balance.¹⁸ A similar conclusion was reached by the Seventh Circuit.¹⁹ In *Allegheny General Hospital*,²⁰ the Board attempted to explain more clearly its rationale in maintenance unit cases, but that effort was not accepted judicially either.²¹ Board Members could agree neither on the general test to apply, nor on the correct results in particular cases.²² A further effort at clarification was made in *St. Francis Hospital*, 265 NLRB 1025 (1982) (*St. Francis I*), which itself contained two separate dissents. Thereafter, the Board issued the aforementioned *St. Francis II* decision, attempting to apply the disparity test so as, it said, better to follow Congress' admonition against undue proliferation. As noted, the D.C. Circuit found that that decision itself represented a misreading of the statute.

¹⁷ *St. Vincent's Hospital*, 223 NLRB 638 (1976).

¹⁸ *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

¹⁹ *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

²⁰ 239 NLRB 872 (1978).

²¹ *Allegheny General Hospital v. NLRB*, 608 F.2d 905 (3d Cir. 1979), denying enf. of 239 NLRB 872.

²² One court stated the Board's opinions in this area were in a state of "disarray." *Long Island College Hospital v. NLRB*, 566 F.2d 833, 843-444 (2d Cir. 1977), cert. denied 435 U.S. 996 (1978).

Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.

II. Disparity Versus Community Of Interests

In reflecting on the court opinions mentioned above, the Board notes that most courts have tended towards either a "community of interests" or "disparity of interests" test. Though these tests over the past decade or so have developed a "life of their own," and have been taken to refer to more or fewer units, respectively, we believe it appropriate to repeat an earlier Board observation in one lead case, *Newton-Wellesley Hospital*, *supra*, that various courts' "disagreement with our approach may be largely semantic."²³ As the Board there noted:

The Board's inquiry into the issue of appropriate units, even in a non-health care industrial setting, never addresses, solely and in isolation, the question whether the employees in the unit sought have interests in common with one another. Numerous groups of employees fairly can be said to possess employment conditions or interests "in common." Our inquiry - though perhaps not articulated in every case - necessarily proceeds to a further determination whether the interests of the group sought are sufficiently distinct from those of other employees to warrant the establishment of a

²³ 250 NLRB at 411-412.

separate unit. We respectfully suggest that, at least to that extent, the test of "disparateness" described by the court is, in practice, already encompassed logically within the community-of-interest test as we historically have applied it, and, accordingly, we interpret the court's direction to the Board to be one of emphasis or degree, and not embracing a distinction of kind.

In one case, after chronicling the checkered and largely unfavorable treatment the Board's broadly stated principles have received from reviewing courts, the Second Circuit concluded that a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account."²⁴ The court suggested that perhaps courts "focus * * * on what the Board did as much as on what it said."²⁵

The court's analysis of what the Board has done in its hitherto "doctrinal" approach to health care unit cases was echoed in the description of this process offered by one scholarly commentator:²⁶

Rather than providing a basis for decisions that only a supposedly expert agency could make - by evaluating the available empirical, economic literature and systematically distilling the accumulated experience of Board personnel

²⁴ *Masonic Hall v. NLRB*, 699 F.2d at 637.

²⁵ *Id.*

²⁶ Estreicher, *Policy Oscillation of the Labor Board: A Plea for Rulemaking*, in proceedings of NYU 37th Annual National Conference on Labor (1984), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

and of the labor relations community generally - the Board acts as a kind of Article I "Talmudist" court, parsing precedent, divining the true meaning of some Supreme Court ruling, and balancing in some mysterious fashion competing, yet absolute-sounding values.

The Board has decided that, rather than formulating yet another broadly phrased test for determining appropriate health care units, perhaps a new approach is needed.

III. The Decision To Engage In Rulemaking: Doctrinal Versus Empirical Approach

The focus of all appropriate unit decisions in the health care industry has been the congressional admonition against "undue proliferation." As described in detail above, some Board Members, and some courts, have believed that this permitted a "community of interests" test, with special emphasis on avoiding proliferation. Others have believed this mandated or at least suggested a "disparity of interest" test, with the same emphasis. As noted, the Second Circuit in *Masonic Hall* believed the real test was in the result reached by the Board, i.e., what unit or units were in fact found appropriate. Indeed, at the end of its decision in *Masonic Hall*, the court observed, perhaps wistfully, that "empirical data is not before us."²⁷

It is clear to us that the key element in the Board's avoidance of proliferation is to designate how many units will be deemed appropriate in a particular type of health

²⁷ 699 F.2d at 642.

care facility. In so doing, the Board must effectuate section 7 rights by permitting bargaining in cohesive units, units with interests both shared within the group and disparate from those possessed by others; weighed against this must be Congress' expressed desire to avoid proliferation in order to avoid disruption in patient care, unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages, and increased costs due to whipsaw strikes and wage leapfrogging.²⁸ Though the Board has of times made broad generalizations as to which types of unit configurations would or would not lead to proliferation and the catalogue of undesired results, it cannot be denied that it has never obtained empirical data on these matters. This, along with the still unsettled state of the Board's past, doctrinal efforts after so many years, is on major reasons for the Board's deciding to engage in rulemaking.

Another major reason is a reflection of the Board's extensive experience. The Board has in the last 13 years received many hundreds of petitions for health care units. Generally, the units requested have been in approximately six predictable groupings: registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees.²⁹ Only occasionally have units of guards or physicians been sought. It is our observation that these groups of

²⁸ See description of the legislative history contained in *Masonic Hall*, 699 F.2d at 631-632.

²⁹ See *St. Francis I.* 265 NLRB at 1029.

employees generally exhibit the same internal characteristics and relationship to other groups of employees, in one health care facility as do like groups of employees at other facilities. To put the matter another way, the various health care facilities we have examined over the years have looked very much the same as other facilities of the same type: large acute care hospitals, small acute care hospitals, and nursing homes.³⁰

To give a more specific example, we have observed that registered nurses perform essentially the same duties at all large acute care hospitals, regardless of which large hospital is involved. Differences are insignificant. For example, despite the emphasis by counsel in the oral argument in the recent *St. Vincent* case (19-RC-11496) on the fact that, in that case, not all RNs were in a single nursing department, we note that the precise same situation prevailed in *Mercy Hospitals of Sacramento*, supra, the first lead case involving registered nurses after the 1974 amendments.³¹ Similarly, it has been our experience that RNs from hospital to hospital receive more or less the same training, uniformly administer drugs and to some extent oversee the work of aides, work at shifts throughout the day and night and on weekends, etc. Despite these similarities, which we are certain are apparent to any labor law practitioner or other knowledgeable person

³⁰ Beyond these types of facilities we are not yet able to generalize and so do not now propose to engage in rulemaking.

³¹ 217 NLRB at 768. The Board in the early *Mercy* case permitted the 27 RNs working in departments other than nursing to vote under challenge.

in the health care field, the Board has undertaken to elicit extensive evidence on RNs' duties at each facility sought to be organized, in order to "adjudicate" the appropriate unit in each case. This has come at a tremendous cost to the hospitals, to unions, and to the Board itself, which must furnish hearing officers, court reporters, and lawyers to help the Members decide the cases, based on the heretofore enunciated generalized "doctrines." To the extent one record is different from another, it would appear that is largely the result of counsels' skill or determination in seeking to demonstrate "interchange," "contacts," and the like, mirroring the requirements that have been set forth by the Board in its latest "lead" case. Registered nurses can be expected to communicate with pharmacists about medications, and with maintenance employees about airconditioning systems, regardless of the facility. Especially in light of the fact that, after 13 years, we are no further along in achieving consensus over doctrine than we were in 1974, and since in any event we are convinced that laborious, costly, case-by-case recordmaking and adjudication in this remarkably uniform field has proved to be an unproductive expenditure of the parties' and the taxpayers' funds, we have decided to engage in rulemaking. The Board is of the opinion that rulemaking, though perhaps time consuming at the outset, will be a valuable long-term investment, paying dividends in the form of predictability, efficiency, and more enlightened determinations as to viable appropriate units, leading ultimately to better judicial and public acceptance.

IV. Power To Engage in Rulemaking

Section 6 of the National Labor Relations Act expressly gives the Board power to make substantive rules:

The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of this Act.

This is the standard grant of general rulemaking authority given to Federal agencies. The function of such a grant of legislative rulemaking authority is to permit an administrative agency to fill in the interstices of the Act it administers through the quasi-legislative promulgation of rules to be applied in the future, with the choice between proceeding by general rule or by individual, ad hoc litigation "one that lies primarily in the informed discretion of the administrative agency."³²

Both sections 9(b) and 9(c)(1) on their face appear to give the Board discretion to make unit determinations. It has been argued that the language of section 9(b) requires a separate determination "in each case," and thus that rulemaking as to units is statutorily prohibited. We do not agree. The adaptability of rulemaking proceedings to unit determinations was considered by Kenneth Culp

³² *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 414.

Davis, perhaps the leading authority on administrative law, who concluded:

The Labor Management Relations Act provides: "The Board shall decide in each case whether . . . the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . ." Do the words "in each case" mean that the Board is prohibited from classifying problems, from developing rules or principles, or from relying on precedent cases which establish narrow or broad propositions? The answer has to be clearly no; the Board may decide "in each case" with the help of such classifications, rules, principles, and precedents as it finds useful. The mandate to decide "in each case" does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents. Sensible men could not refuse, to use such instruments and a sensible Congress would not expect them to. [Davis, *Administrative Law Text* 145 (3d ed. 1972.)]

The Supreme Court urged the Board to use its rulemaking powers in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969). As Justice Douglas there stated:

The rule-making procedure performs important functions. It gives notice to an entire segment of society of those controls or regimentation that are forthcoming. It gives an opportunity for persons affected to be heard. . . . Agencies discover that they are not always repositories of ultimate wisdom; they learn from the suggestions of outsiders and often benefit from that advice. . . . This is a healthy process

that helps make a society viable. The multiplication of agencies and their growing power makes them more and more remote from the people affected by what they do and make more likely the arbitrary exercise of their powers. Public airing of problems through rule-making makes the bureaucracy more responsive to public needs and is an important brake on the growth of absolutism in the regime that now governs all of us. . . . Rule making is no cure-all; but it does force important issues into full public display and in that sense makes for more responsible administrative action. [Id. at 777-779].

Moreover, Congress in 1978 considered, though it failed to pass, legislation that would have required the Board to embrace rulemaking in several areas, including an elaboration of appropriate bargaining units. The Senate committee, in endorsing S. 2467, went so far as to state that "there is no labor relations issue on which there has been such a strong consensus of scholarly opinion as on the proposition that the Board should make greater use of its rulemaking authority under section 6 of the Act."³³

³³ As reported in BNA Special Supplement, DLR, p. 7 (Feb. 6, 1978). Among the many scholars referred to were Peck, *The Atrophied Rule Making Powers of the NLRB*, 70 Yale L.J. 729 (1961); Peck, *A Critique of the National Labor Relations Board's Performance in Policy Formation: Adjudication and Rule Making*, 117 U. Pa. L. Rev. 254 (1968); Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 Harv. L. Rev. 921 (1965); Bernstein, *The NLRB's Adjudication-Rulemaking Dilemma Under the Administrative Procedure Act*, 79

(Continued on following page)

Thereafter, the Seventh Circuit, tired of a case-by-case analysis (on a charge nurse-supervisory issue), stated: "while the Board is entitled to some judicial deference in interpreting its organic statute as well as in finding facts, it would be entitled to even more if it had awakened its dormant rulemaking powers for the purpose of particularizing the application * * * to the medical field." *Hillview Health Care Center*, 705 F.2d 1461, 1466 (7th Cir. 1983).

Recent observers of the Board have been similarly supportive.³⁴ In one recent article, Professor Charles Morris, editor in chief of *The Developing Labor Law*, suggests that "Substantive rulemaking pursuant to the Administrative Procedure Act (APA) and Section 6 of the NLRA is probably the most important thing the Board can do to effectuate its process, economize its time, and advise the people who need to know - most of whom are not lawyers - what the law requires."³⁵ Morris urges rulemaking with particular reference to collective-bargaining units in the health care industry.³⁶ As Morris

(Continued from previous page)

Yale L.J. 571 (1970); Kahn, *The NLRB and Higher Education: The Failure of Policymaking through Adjudication*, 21 U.C.L.A. L. Rev. 63 at 167-175 (1973); Silverman, *The Case for the National Labor Relations Board's Use of Rulemaking in Asserting Jurisdiction*, 25 Labor L.J. 607 (1974); and Davis, *Administrative Law Treatise* section 6.17 (1970 Supp.).

³⁴ Estreicher, *supra* at fn. 20; Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105 (1981).

³⁵ Morris, *The NLRB in the Dog House - Can an Old Board Learn New Tricks?*, 24 San Diego L.R. 9 (1987), p. 27.

³⁶ *Id.* at 41. fn. 149.

suggests, "The wheel need not be reinvented in every case."³⁷

In deciding to engage in rulemaking with respect to appropriate bargaining units in the health care industry, it is the Board's desire to substitute for hitherto unsuccessful doctrines, and lengthy and costly litigation by the parties to each case who seek primarily to advance their own interests in that case, informed rulemaking. In the course of that process, the Board seeks to obtain that empirical evidence that is one of the chief reasons for engaging in rulemaking,³⁸ and that was alluded to by the Second Circuit in *Masonic Hall*, 699 F.2d at fn.26.

Depending on the numbers of institutions or persons who desire to give oral testimony, it is the Board's intention to conduct a group of hearings, at which knowledgeable persons can give testimony as to how bargaining in the various units at different types of health care institutions has worked. The Board wants to learn how various bargaining units affect legitimate concerns of both unions and health care employers. For example, when registered nurses have been grouped with other professionals, have their interests been properly represented? Has the bargaining, when it has occurred in all-professional groups, nonetheless proceeded on the basis of each separate profession? Have wage rates been negotiated separately despite the all-professional units? When they have existed, have separate professional groupings resulted in

³⁷ *Id.* at 34.

³⁸ Morris, *supra* at 29, 31. See also Subrin, *supra* at 108-109, 111.

interruption in the delivery of health care? Wage whipsawing? Jurisdictional disputes? These are merely examples of the types of questions that should be addressed by anyone testifying for or against separate units, such as registered nurses, business office clericals, technicals, maintenance employees, etc. The Board is not seeking at the oral hearings the "opinions" and further legal arguments of counsel, which may be submitted as comments, but, rather, actual, empirical, practical evidence offered by industry and union representatives who have themselves participated in or observed bargaining in the health care industry in various configurations. The Board also desires evidence from witnesses with direct knowledge about any recent changes in the delivery of health care, such as cost containment, allegedly greater integration of function between categories of health care employees, and changes in function of specific classifications of health care employees, including greater or lesser degrees of specialization, that may have an impact on the question of appropriate units.

We trust that after receiving and studying such empirical evidence, we will be better able to make an informed judgment as to what units should be found appropriate in the health care industry, because they reflect true community/diversity of interests and do not promote but instead minimize the type of proliferation and interruption of care which concerned Congress in passing the 1974 amendments. No small additional advantage, we hope, will be the attainment of a greater measure of judicial and public deference to what will be our better informed judgment and expertise, with the

long-run advantage of settling, finally, the difficult question of appropriate bargaining units in the health care industry.

V. Proposed Rulemaking

The proposed rule which follows is a new endeavor for the National Labor Relations Board, but not for labor-management agencies generally. A number of States have engaged in rulemaking with respect to appropriate bargaining units for their own employees.³⁹ The proposal that petitions be entertained only in the proposed units is patterned after a similar provision in the Florida and Massachusetts rules. We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers; moreover, as previously indicated, our experience has been that facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical. Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations; the exception is to be construed narrowly and is not intended to provide an opportunity (or loophole) for redundant litigation. The preamble is by its terms limited to petitions for initial organization, since historically the Board has required decertification petitions to be filed in the

³⁹ See, e.g., *in the Matter of State of Florida*, 2 FPER 111 (June 17, 1976). Also, amendment to the Rules and Regulations of Massachusetts Labor Relations Commission, adopted 3 March 1975.

certified or recognized unit.⁴⁰ When institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible.

There is a provision that the listed units will be the only appropriate units, except that any combination will also be appropriate at the union's option and so long as the requirements of section 9(b)(1) and (3) are met. The union is given the option because the Board will have determined that the dictated number of units do not proliferate, and a petition for one of them will be processed to an election without extensive testimony on that issue; a combination would a fortiori be appropriate, since it would proliferate even less. The reference to section 9(b)(1) is included since the statute requires a self-determination election when professionals are sought to be included with nonprofessionals; a combination of these groups, as with RNs (professionals) and LPNs (technicals) at a nursing home, would have to satisfy the 9(c)(1) requirements through the conduct of a *Sonotone*⁴¹ election. Similarly the reference to section 9(b)(3) is included because the statute prohibits the inclusion of guards in bargaining units with other employees.

The proposed rule divides health care facilities into three separate groups. The Board has tentatively decided, based on its experience, that larger hospitals, with their larger numbers of employees in each category, may warrant one or two additional units. In smaller facilities, it is likely that employees will have more contacts with one

⁴⁰ *Cambell Soup Co.*, 111 NLRB 234 (1955).

⁴¹ *Sonotome Corp.*, 90 NLRB 1236 (1950).

another, may to some extent perform one another's work, and generally may share interests more than groupings in larger hospitals.⁴² A slightly lesser degree of specialization seems also probable. Recognizing that perfection is impossible in this area, but also being intent on not litigating the precise boundaries of the "small hospital" in each case,⁴³ the Board has tentatively determined that acute care⁴⁴ hospitals of more than 100 patient beds will be deemed "large"; acute care hospitals of 100 patient beds or fewer will be deemed "small." The Board will be grateful for interested parties' comments about these definitions during the comment period. No definition of nursing homes seems required. The Board leaves to future proceedings rules with regard to other types of health care facilities.

As for the proposed units, the Board gave considerable thought merely to advising the public that it had decided to engage in rulemaking, leaving wide open the substance of any rule. However, we have decided to offer a proposal with more specifics, solely for purposes of focusing the debate. It is our best judgment that having such a proposal on the floor, for debate, will prove more fruitful than merely inviting open-ended commentary. However, the Board wishes to make it abundantly clear that while the proposed units at this point are based on the Board's cumulative experience and observation, the

⁴² See, e.g., *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981); see also 217 NLRB 802 (1975).

⁴³ Subrin, *supra*, pp. 106-7.

⁴⁴ Sec. 2(14) refers to, *inter alia*, "hospitals" and "convalescent hospitals."

Board has a completely open mind about which and how many units it will ultimately settle upon. That is the purpose of the comment period and hearings provided for, and the Board will reassess its proposed units before issuing a final rule.

The proposed rule notes that "nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules, where appropriate, about such matters." That is, after this proceeding, in which the Board will determine the contours of appropriate units, the Board may commence additional rule making proceedings to determine the composition of these units, including the professional or technical status of certain classifications which we have encountered frequently in health care cases. As an example, we are advised that there is currently before one regional office a case⁴⁵ in which the petition was filed 10 October 1986; hearing commenced 14 November 1986. As of 20 May 1987, the board had taken testimony covering 24 days of hearing, with more scheduled, covering 5978 transcript pages plus 300 exhibits. At issue is the petitioner's desire for a unit of all service, maintenance, clerical and technical employees with a "community of interest," as opposed to the employer's contention that only an all nonprofessional unit is appropriate. Essentially, the parties differed over the placement of business office clericals, and technicals "without a community of interest," but to some extent 300 classifications were in dispute, some as to

⁴⁵ *Christ Hospital*, 9 - RC - 15019.

whether they were technical or professional, and as to whether they shared interests in common with other, included categories. It has been our observation that classifications in the health care industry are to a large degree standardized, and that future rulemaking to determine what classifications are technical, if that unit is ultimately deemed appropriate, or, alternatively, professional, might further shorten proceedings by eliminating duplicative and in some cases self-evident testimony.

The proposed rule notes that the Board will approve consent agreements providing for elections in accordance with the rule, and that nonconforming agreements will be rejected. Further, the rule will be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

VI. Justification For Proposed Units

Initially, we emphasize that, except for information we have gleaned from our decided cases, our proposed rule is not based on empirical evidence concerning health care facilities generally. We anticipate that the testimony and commentary we receive in the course of the rulemaking process will contain a significant amount of the empirical data we need in order to verify or modify our original ideas as to which bargaining units are appropriate.

In formulating our proposed rule, we have, of course, kept firmly in mind Congress's admonition against proliferation of health care bargaining units. However, we also have been mindful of our statutory mandate to make unit

determinations "in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the] Act."⁴⁶ In addition, we have deemed it significant that the 1974 amendments were intended to encourage collective bargaining by hospital employees in order to improve wages, working conditions, and morale among those employees, reduce turnover, and improve the quality of hospital care.⁴⁷ We thus agree with the Second Circuit Court of Appeals that the legislative history of the amendments "does not direct the courts or the Board to erect obstacles to certification of bargaining units that are broader and higher than Congress was itself willing to enact."⁴⁸ Consequently, we have drafted the proposed rule with the intent of affording health care employees the "fullest freedom" to organize, while at the same time attempting to avoid the proliferation of bargaining units in that industry that so concerned Congress. We have sought to accomplish this, not by promulgating an abstract standard, but rather by satisfying ourselves that we have limited the possible units in the various types of establishments to a reasonable, finite number of congenial groups displaying both a community of interests within themselves and a disparity of interests from other groups.

The specific units contained in the proposed rule were included, and other possible units were omitted, for the following reasons:

⁴⁶ Sec. 9(b) of the Act, 29 U.S.C. 159(b).

⁴⁷ *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497-498 (1978); see also *Masonic Hall*, 699 F.2d at 634.

⁴⁸ *Id.* at 635.

A. Large Acute Care Hospitals

1. *Registered Nurses (RNs)*. Because of the numerous differences that commonly exist between RNs and other professional employees, we have tentatively determined that, in large hospitals, separate RN units are appropriate for bargaining. Thus, in comparison with most other professionals, RNs usually work three shifts, round the clock, 7 days a week, have constant responsibility for direct patient care, and are subject to common supervision by other nurses.⁴⁹ RNs also share similar education, training, experience, and licensing that are not shared by other hospital employees.⁵⁰ Although RNs do have contact with certain other professionals, such as pharmacists, social workers, and physical therapists, such contacts tend to be less frequent than the RNs' contacts with one another.⁵¹ Moreover, RNs have a lengthy history of organization, both professionally and for purposes of collective bargaining.⁵² Finally, because our experience has shown that RNs comprise the largest group of professional employees at most health care facilities, granting them (but not other individual professions) their own separate unit will not contribute significantly to proliferation of bargaining units.⁵³

⁴⁹ See, e.g., *Newton-Wellesley Hospital*, 250 NLRB at 410-411, 413.

⁵⁰ *Id.* at 409, 413.

⁵¹ *Id.* at 410.

⁵² *Mercy Hospitals of Sacramento*, 217 NLRB at 767.

⁵³ *Newton-Wellesley Hospital*, 250 NLRB at 414-415.

2. *Physicians.* For the purposes of the Act, most physicians employed by hospitals are considered either supervisors, managerial employees, or (in the case of interns and residents) students,⁵⁴ and hence do not have statutory organizational rights. Accordingly, we envision very few, if any, petitions for separate physicians' units. However, because of physicians' separate education, training, and skills, and particularly because of their unique position as the ultimate supervisors of patient care, we deem it necessary to provide for the possibility of such units in the event they are requested.

3. *Other professional employees.* Section 9(b)(1) of the Act mandates separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with nonprofessionals.⁵⁵ The statute thus requires that professional employees not be combined in bargaining units with nonprofessional employees without the consent of the former.⁵⁶ While, therefore, a separate unit consisting of all professional employees unquestionably is an appropriate unit for bargaining, for the reasons set forth above, we have (provisionally) determined that separate registered nurses' units also are appropriate. However, in light of the congressional admonition against proliferation of bargaining units, we have determined at this time not to approve separate units of other individual professional employee classifications. Otherwise, we believe, the door would be

⁵⁴ *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976).

⁵⁵ 29 U.S.C. 159(b)(1).

⁵⁶ *Sonotone Corp.*, *supra*.

open to the very fragmentation of bargaining units Congress directed the Board to avoid.

4. *Technical employees.* In our experience, technical employees in hospitals and nursing homes, in comparison with other nonprofessionals, typically have significantly higher levels of skill and training, and are substantially higher paid.⁵⁷ Consequently, we have consistently approved separate units of health care technical employees and excluded technicals from units of other nonprofessional employees.⁵⁸ Our determinations generally have met with approval from the courts of appeals.⁵⁹ Based on our current state of knowledge, we do not discern any reason to depart from our existing practice at this time.

5. *Service, maintenance, and clerical employees (except for Guards).* Service and maintenance employees generally do routine manual work, are not highly skilled or trained, and are paid less than technical employees; consequently, we normally approve separate service and maintenance units.⁶⁰ Such determinations have met with court

⁵⁷ See, e.g., *Southern Maryland Hospital*, 274 NLRB 1470 (1985).

⁵⁸ *Id.* See also *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975); *Newington Children's Hospital*, 217 NLRB 793 (1975).

⁵⁹ See, e.g., *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (8th Cir. 1983).

⁶⁰ See, e.g., *Newington Children's Hospital*, *supra*. In that case we observed that "a service and maintenance unit in a service industry is the analogue to the plantwide production and maintenance unit in the industrial sector, and as such is the classic appropriate unit." 217 NLRB at 794.

approval.⁶¹ Our proposed rule, however, adds two groups of employees which labor organizations sometimes seek to represent separately, or which labor organizations have sometimes excluded from broader service and maintenance units: clericals and skilled maintenance employees.

We acknowledge that the Board at one time found separate units of business office clerical employees appropriate in health care facilities.⁶² More recently, however, our experience has indicated that clericals often share many terms and conditions of employment with service and maintenance employees, and that the two groups have regular, frequent, and significant contacts on the job.⁶³ Moreover, many employees in health care institutions, besides business office clericals, are engaged in "recordkeeping," such as ward clericals, technicians, nurses, and even physicians. Further, to the best of our knowledge no labor organization has specialized in the representation of business office clericals. For these reasons, and to avoid the proliferation of bargaining units, we have chosen tentatively to include clericals in service and maintenance units. We emphasize, however, that no final decision has been made, and that if evidence exists suggesting that clericals have a distinct community of interests, and that their separate representation would

⁶¹ See, e.g., *Masonic Hall*, supra.

⁶² See, e.g., *Sisters of St. Joseph of Peace*, 217 NLRB 797 (1975).

⁶³ See, e.g., *Baker Hospital*, 279 NLRB No. 38 (Apr. 16, 1986).

not have unwanted adverse results, such evidence should be presented at the hearings.

Similarly, although at times the Board has in the past approved separate units of skilled maintenance employees (including stationary engineers),⁶⁴ in our proposed rule we have provisionally included such employees in service and maintenance units for several reasons. First, we have found that their skill levels at times do not greatly exceed those of other unit employees.⁶⁵ Second, many skilled maintenance employees work throughout hospitals' facilities, and thus frequently come into contact with other unit employees.⁶⁶ Third, inclusion of skilled maintenance employees in broader units will help to prevent unit proliferation. By contrast, if we were to approve separate skilled maintenance units, many of which would be quite small both in absolute size and relative to the remaining service and maintenance employees, we might well be faced with requests to grant other small units of specialized employees; were we to grant such requests, we would

⁶⁴ See, e.g., *Allegheny General Hospital*, 239 NLRB 872 (1978), enf. denied 608 F.2d 965 (3d Cir. 1979); *Mercy Hospital Assn.*, 238 NLRB 1018 (1978), enf. denied 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *Mary Thompson Hospital*, 241 NLRB 766 (1979), enf. denied 621 F.2d/858 (7th Cir. 1980); *West Suburban Hospital*, 227 NLRB 1351 (1977), enf. denied 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital*, 227 NLRB 544 (1976), enf. denied 567 F.2d 588 (3d Cir. 1977). But see *St. Francis II*, supra, and *Shriners Hospital for Crippled Children*, 217 NLRB 806 (1975), denying separate maintenance units.

⁶⁵ *St. Francis II*, 271 NLRB at 954.

⁶⁶ *Id.* *Community Hospital at Glen Cove*, 278 NLRB No. 18 (Jan. 17, 1986).

open the door to unit fragmentation and proliferation.⁶⁷ Finally, as a practical matter, when the Board has approved separate maintenance units, its decisions have fared poorly in the courts.⁶⁸

6. *Guards.* Section 9(b)(3) of the Act requires that guards not be included in a unit with other employees,⁶⁹ and therefore separate guard units must be provided for. Our experience indicates, however, that in practice extremely few guard units are petitioned for, perhaps because hospitals often do not employ guards directly, but instead obtain guards from security services.

B. *Small Hospitals and Nursing Homes*

Our proposed rule contains the same units for small hospitals and nursing homes as for large hospitals, except that instead of providing for separate units of physicians

⁶⁷ *Shriners Hospital for Crippled Children*, 217 NLRB at 808. Partly because of the size of the employee groups involved, our tentative decisions to approve separate units for RNs in large acute care hospitals, but not maintenance employee units, are not inconsistent. Maintenance employees usually are few in number, whereas RNs, we have observed, almost always are numerous in absolute terms and typically comprise the majority of professional employees. Maintenance employees are aptly compared to members of other specialized professional or technical groups, such as pharmacists or medical technicians. Although each group is set apart from others to some degree by differing skills, training, etc., under the proposed rule we would not approve separate, specialized units for any such group, but instead would combine them into broader units.

⁶⁸ See fn.64, *supra*.

⁶⁹ 29 U.S.C. 159(b)(3).

and RNs, it provides for all-professional units. We have tentatively eliminated the narrower units in favor of broader ones because we think that in smaller facilities there will be found less division of labor and specialization, and thus more functional integration of employees' services, than normally is the case in large hospitals. We also expect that there are far fewer professionals other than physicians and nurses in the smaller facilities (especially in nursing homes), and therefore that separate units of "other professionals" are less likely to be appropriate.

VII. *Public Hearings*

The Board will hold public hearings concerning appropriate bargaining units in the health care industry. The Board wishes to receive testimony and oral presentations from individuals who have direct knowledge of practices in this industry that may have impact on both the number and types of collective-bargaining units that will be permitted. More details about the type of evidence the Board will consider relevant are set forth in section IV above.

The hearings will be conducted at the following locations on the dates indicated:

(1) *Washington, DC* – The hearing will commence at 9 a.m. on August 17, 1987, in the Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue NW., Washington, DC 20570.

(2) *Chicago, Illinois* – The hearing will commence on August 31, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary

(see address section) or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353-7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California* – The hearing will commence on September 14, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary (see address section) or the Board's San Francisco Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995-5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the Office of the Executive Secretary, 1717 Pennsylvania, Avenue NW., Washington, DC 20570, telephone number (202) 254-9430, no later than July 24, 1987, advising it of the location at which the witness wishes to testify. Thereafter, all witnesses should submit to the Executive Secretary at the above address eight copies of either the written text or a summary of their presentations no later than 1 week prior to the commencement of the hearing at which they wish to testify. Copies of these texts and summaries will be placed in the docket (see sec. VIII, *infra*) and will be available at the Executive Secretary's Office, and also at the hearing location where the witness intends to testify, for examination by interested persons.

Any member of the public may file a written statement (eight copies) in lieu of oral testimony before, during, or after the hearing, provided that such statement is

received by the Board on or before October 30, 1987. Written statements should be addressed to the NLRB's Executive Secretary at the address given in the address section of this preamble, and should refer to Docket No. RM-2.

An administrative law judge will preside over the hearings, which will be informal, legislative-type proceedings at which there are no formal pleadings or adverse parties. In general, oral presentations from individual witnesses will be limited to 20 minutes each, except that the presiding judge may impose a greater or lesser period, at the judge's discretion, if he or she deems it appropriate. Participants may desire to ask questions or crucial issues following a presentation. Such questions may be permitted by the judge, limited to approximately 15 minutes per questioner. Questions must be designed to clarify a presentation and/or elicit information that is within the competence or expertise of the witness; questions that are argumentative or in the nature of a statement will not be permitted. The judge shall have discretion to modify the time for questioning, and shall have further discretion to impose other guidelines for the orderly and efficient conduct of the hearing. This shall include the right to require a single representative to present the views of two or more persons or groups who have the same or similar interests, and to identify such persons or groups with similar interests.

The Board will be represented at the hearings by a member of its staff. The judge and the Board representative shall have the right to question persons making an oral presentation as to their testimony and any other relevant matter.

Comments may be submitted which include data, views, or arguments concerning the proposed rulemaking. These should be submitted (in eight copies) to the Executive Secretary, at the address given in the address section of this preamble, and should refer to Docket No. RM-2. Comments must be submitted by the close of the comment period, which is October 30, 1987.

A verbatim transcript of the hearings, and the written statements and comments, will be available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, DC (see address section of this preamble).

VIII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so that they can participate effectively in the rulemaking process and (2) to serve as the record in case of judicial review.

As required by the Regulatory Flexibility Act, it is hereby certified that this rule will not have a significant impact on small business entities.

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the preamble, it is proposed to amend 29 CFR Part 103 as follows:

PART 103 - OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: Section 6, National Labor Relations Act, as amended (29 U.S.C. 151, 156), and section 553 of the Administrative Procedure Act (5 U.S.C. 500, 553).

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C - Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) With respect to employees of "health care institutions" as defined in section 2(14) of the Act, no petition for initial organization shall be entertained, except under extraordinary circumstances, if the petition seeks certification in a bargaining unit not in substantial accordance with the provisions of this rule. The following shall be the only appropriate units, except that any combination will also be appropriate, as the union's option and so long as the requirements of section 9(b)(1) and (3) are met:

(1) Appropriate units in large, acute care hospitals, which shall be defined as all acute care hospitals having more than 100 patient beds:

(i) all registered nurses.

(ii) All professionals except for registered nurses and physicians.

(iii) All physicians.

(iv) All technical employees.

(v) All service, maintenance and clerical employees except for guards.

(vi) All guards.

(2) Appropriate units in small, acute care hospitals, which shall be defined as all acute care hospitals having 100 patient beds or fewer:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(3) Appropriate units in all nursing homes:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(4) Appropriate units in all other health care facilities:

The Board for the time being will establish appropriate units in other health care facilities on a case-by-case basis.

(b) Notwithstanding the above, nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters. The Board will approve consent agreements providing for elections in accordance with the above rules, and no other agreements will be approved. This rule is to be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

Dated, Washington, DC, June 26, 1987.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 87-14895 Filed 7-1-87; 8:45 am]

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NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

**Collective-Bargaining Units
in the Health Care Industry**

AGENCY: National Labor Relations Board.

ACTION: Second notice of proposed rulemaking.

SUMMARY: This Second Notice of Proposed Rulemaking provides for appropriate bargaining units for various types of facilities in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

DATE: Comments must be received on or before October 17, 1988.

ADDRESS: Comments should be submitted in eight copies to: Office of the Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

FOR FURTHER INFORMATION CONTACT: Curtis A. Wells, Associate Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION: The following is an outline of the contents of this Notice:

- I. Background
- II. Validity and Desirability of Rulemaking

III. Standard to be Applied in Determining Appropriate Units

IV. Two Units: All Professionals/All Non-Professionals

V. Registered Nurses

VI. Physicians

VII. Other Professionals

VIII. Technicals

IX. Skilled Maintenance

X. Business Office Clericals

XI. Other Non-Professionals

XII. One Hundred Bed Distinction

XIII. Nursing Homes

XIV. Specialized Hospitals

XV. Partially Organized Facilities

XVI. Facilities Covered

XVII. Decisions to Which Rule Applies

XVIII. Non-Conforming Stipulations

XIX. Combined Units

XX. Extraordinary Circumstances Exception

XXI. Proliferation

XXII. Docket

XXIII. Regulatory Flexibility Act

XXIV. Regulatory Text

XXV. Dissenting Opinion

I. Background

In our original Notice of Proposed Rulemaking (NPR), we set forth at considerable length the reasons prompting the Board to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25142-25145, July 2, 1987.

Following the Notice, the Board conducted the three hearings announced in the Notice, as well as a fourth hearing requested by several interested parties and announced at 52 FR 29038. At these hearings, all who wished to testify were given an opportunity to do so, and all who wished to ask questions of the various witnesses were given that opportunity. Summaries (cited below as WS) submitted in advance by most of the prospective witnesses facilitated the questioning process.

The first hearing was held in Washington, DC on August 17 and 18, 1987; 20 witnesses appeared, and 496 pages of testimony were taken.

The second hearing was in Chicago, Illinois on August 31 and September 1, 1987; 27 witnesses appeared, and 521 pages of testimony were taken.

The third hearing was in San Francisco, California on September 14, 15, and 16, 1987; 39 witnesses appeared, and 762 pages of testimony were taken.

The final and longest hearing was back in Washington, DC on October 7, 8, 9, 13, 14, 15, and 16, 1987; 58 witnesses appeared, and 1766 pages of testimony were taken.

The comment period, which was originally to last through October 30, 1987, was thereafter extended three times upon the request of various parties [52 FR 36589, 43919, and 47029]. The evidence received by the Board at the hearings and during the comment period substantially exceeded, in both detail and exhaustiveness, what the Board had expected. The transcript of hearing totals 3545 pages, and the 144 individuals who came in person to testify included employees from virtually every broad classification under consideration: registered nurses, physicians, other professionals, technicals, skilled maintenance employees, service and related employees, and business office clericals. In addition, there were union and management negotiators from around the country; a number of professors of nursing, health care management, and other academic disciplines; hospital administrators; health care associations such as the American Medical Association (AMA); representatives of numerous unions including the American Federation of Labor and Congress of Industrial Organizations (AFL), Service Employees International Union (SEIU), International Brotherhood of Teamsters (IBT), United Food and Commercial Workers International Union (UFCW), International Union of Operating Engineers (IUOE), American Nurses Association (ANA) and several of its state associations, Hospital Employees' Labor Program of Metropolitan Chicago (H.E.L.P.), United Nurses' Association of California (UNAC), Communication Workers of America

(CWA), Union of American Physicians and Dentists (UAPD), New York State Federation of Physicians and Dentists; and representatives of various employer groups such as the League of Voluntary Hospitals and Homes of New York, American Hospital Association (AHA), New Jersey Hospital Association (NJHA), Metropolitan Chicago Healthcare Council, Missouri Hospital Association, Ohio Hospital Association, Affiliated Hospitals of San Francisco, California Association of Hospitals and Health Systems, Associated Hospitals of the East Bay, Hospital Council of Southern California, American Health Care Association, and Hospital Council of Western Pennsylvania.

During the comment period, the Board received written comments from 315 individuals and organizations, representing diverse points of view and offering information to supplement what the Board had learned from the oral testimony. These comments alone totalled approximately 1500 pages.

In addition, following the close of the hearings, lengthy comments in the nature of briefs were submitted by the AHA; the ANA; the Building and Construction Trades Department of the AFL-CIO; the IUOE; and the AFL, on behalf of SEIU; National Union of Hospital and Health Care Employees (NUHHCE); Local 1199, Drug Hospital and Health Care Employees Union, Retail, Wholesale, Department Store Union (Local 1199); Federation of Nurses and Health Care Professionals, American Federation of Teachers (AFT); American Federation of State, County and Municipal Employees (AFSCME); CWA; International Union, United Auto Workers; UFCW; and United Steelworkers of America.

The Board is gratified at, and appreciative of, the interest shown in these proceedings by all segments of the industry, including its employees and their representatives. The Board has spent a great deal of time reviewing the evidence collected and the comments received, and believes it is now far better qualified to resolve the issues raised in the Notice of Proposed Rulemaking.

On July 1, 1988, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry. The rules tentatively decided upon in that meeting and proposed below have been derived from our analysis of the empirical evidence and comments received during the rulemaking proceeding. The rules now proposed differ in several important respects from the rules proposed in our original Notice of Proposed Rulemaking. Because this is the Board's first major effort at substantive rulemaking, and because the Board is desirous of giving all interested parties a further opportunity to comment on the proposed rules, including the substantial revisions, we have provided for another period of comment. See, e.g., Note, *The Need for An Additional Notice and Comment Period When Final Rules Differ Substantially From Interim Rules*, 1981 Duke L.J. 377 (1981). This Second NPR contains a lengthy Supplementary Information Sec., addressing the major issues presented and containing numerous citations to the rulemaking record. We wish to emphasize that these citations are merely illustrative of the testimony upon which we relied and are not represented as the entirety of the record. We have carefully studied the complete rulemaking record, including the transcript, the witnesses' statements, the comments and briefs, and the exhibits, and have based

our proposed rules on the entirety of this record, and not solely on the testimony specifically cited.

II. Validity and Desirability of Rulemaking

A. Introduction

The Board's statutory authority to engage in rulemaking is derived from section 6 of the National Labor Relations Act, which expressly gives the Board power to make "such rules and regulations * * * as may be necessary to carry out the provisions of this Act * * *."

In response to several commentators' concerns (e.g., AHA Br. 48: Comment 289. Ross WS Albanese. Charter Medical) and also to the concern expressed by our dissenting colleague, the fact that the language of section 9(b) requires a separate determination "in each case" does not in our opinion mean that the Board cannot promulgate rules to assist it. (See discussion at 52 FR 25144.) It has long been the Board's practice to formulate "rules" to guide it in representation matters. See e.g., the "contract bar rules," discussed in *Appalachian Shale Products Co.*, 121 NLRB 1160 (1958); the "Excelsior Rule," enunciated in *Excelsior Underwear Inc.*, 156 NLRB 1236 (1966); and the *Peerless Plywood* rule, 107 NLRB 427, 429 (1953). Although these rules were formulated by adjudication rather than APA rulemaking, and a majority of the Supreme Court in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969), upheld the validity of the particular rule (the *Excelsior* rule) as applied to the respondent in that case, the plurality implied, and the two dissents explicitly stated, that the Congressionally-preferred course for such

prospective pronouncements would be APA rulemaking. To our knowledge, no court or academic commentator has ever made the contrary suggestion, that section 9(b) forbids utilization of APA procedures to formulate generally applicable representation case rules. As Kenneth Culp Davis observed with specific reference to the language of section 9(b). "The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of 'deciding in each case' are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to." Davis, *Administrative Law Text* 145 (3d ed. 1972).¹

In the Notice of Proposed Rulemaking, we set forth at length our reasons for embarking on this procedure in the health care industry. Initially, we noted that thirteen years had elapsed since the health care amendments were passed, but none of the Board's previously enunciated doctrinal formulas for determining appropriate health care units had yet met with general judicial acceptance. Moreover, in numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the

¹ See also *Continental Web Press v. NLRB*, 742 F.2d 1087, 1093-94 (7th Cir. 1964), in which Judge Posner suggests that the Board's decision in that case with respect to lithographic units would have been more acceptable had the Board used "its dormant rulemaking powers;" and *NLRB v. Majestic Weaving Co.*, 355 F.2d 854, 859-61 (2d Cir. 1966) (Friendly, J.), cited by the court in *Continental Web Press*.

Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, and even under adjudication the various Board members had reached virtually identical results from case to case. Hence, it did not appear that what some have termed "sensitive, case-by-case adjudication" was serving any useful purpose. The Board also acknowledged that for years it had been urged to engage in APA rulemaking by numerous scholars and judges. In making the decision to engage in rulemaking, the Board expressed the expectation that this type of proceeding would produce the type of empirical evidence most appropriate for a determination as to which of the requested groups warranted separate bargaining units, while not creating such undesirable results as excessive proliferation, interruption in the delivery of health care services, jurisdictional disputes, wage whipsawing, and the like. A fuller exposition of the Board's initial reasons for undertaking rulemaking can be found at 52 FR 25143-145.²

Following its issuance of a Notice of Proposed Rulemaking, the Board permitted the parties to comment

² In the NPR, we observed that a number of states, including Florida and Massachusetts, had engaged in rulemaking to formulate appropriate bargaining units for their own employees. 52 FR 25145, fn. 39. We take official notice that, as of November 1987, of the 22 states with comprehensive collective bargaining legislation for state employees, ten (Alaska, California, Connecticut, Florida, Iowa, Maine, Massachusetts, Michigan, New York and Ohio) set their units by administrative rulemaking, and four (Hawaii, Minnesota, Nebraska, and Wisconsin) designate them by statute. Only eight (Illinois, Montana, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island and Vermont) establish units through case-by-case adjudication.

on this matter, and to present testimony in support of their positions. A significant number of health care providers, including the American Hospital Association, opposed the Board's rulemaking efforts. We have carefully considered all their arguments and the evidence submitted in support thereof.

B. Industry's Position

1. *Dynamics and diversity of health care industry.* One argument advanced by a number of employers in opposition to rulemaking was that the dynamics and diversity of the industry preclude it. Thus, the imposition of diagnostic related groups (DRGs) has required new efforts at cost containment (WS Rhodes [AHA] at 1,4; Comment 108, Bonaventure; Comment 130, St. Vincent's Hosp. Ala; Comment 193, Dolly Vinsant Memorial Hospital; Comment 268, Kane). Inflationary pressures have increased while revenues, particularly for in-patient stays, have either decreased or have been governed by ceilings. (Comment 76, South Suburban Hosp.; AHA Br. 3-4; Comment 81, Jordan Hospital; Comment 146, Kennebec Valley Medical Center.) Severe shortages in certain categories of employees have required hospitals to be flexible, which, it is alleged, is inconsistent with the relative inflexibility of rules (Comment 133, Beth Israel Hosp.).

At the same time, there has developed an increasing diversity in hospitals and the services they provide (King, 4232; Comment 19, Johnson City Medical Center Hosp.). Thus, hospitals of all types and sizes are establishing new types of related health care services on outpatient as well as inpatient bases (AHA Br, 5; Dauner, 3217; Comment 44,

McDonough District Hosp.; Comment 71, St. Mary Hosp.; Comment 76, South Suburban Hosp.; Comment 174, High Plains Baptist Hosp.; etc.). Many hospitals are expanding their markets by developing a number of specialty units, such as arthritis units (AHA Br. 7, citing *Modern Healthcare*, July 31, 1987, p. 42); intensive cardiac care, intensive medical/surgical, and neonatal units (Comment 71, St. Mary's Hosp.); trach units, dialysis units, etc. (Comment 78, Greater Cincinnati Hosp. Council). Another change is that hospitals are using part-time workers in increasing numbers to accommodate rapid fluctuations in inpatient census and reduction in full-time employee schedules (AHA Br. 7). One large group of proprietary hospitals, National Medical Enterprises, has extensively analyzed services provided in its hospitals to determine what allegedly professional services could be handled by non-professionals; in some of its facilities, it has implemented the "caregiver" concept to replace traditional job labels, within the limits of the classifications' competency. (Donnelly, 4063-80.) It is alleged that rulemaking is not suited for today's diverse and complex institutions (AHA, King, 4232).

2. *Changing structure.* The industry's witnesses presented evidence that the structure of the industry is changing in that hospitals are becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc. (Rhodes, 9-11; NJHA, 320-324, 325; Dauner, 3194; Comment 66, Holy Cross Health Sys.; Comment 203, Deaconess Hosp.). It is alleged that an inflexible rule will impede the Board's ability to respond quickly to rapid changes in the industry (AHA, pos. st. 2). It is claimed

that, because of the myriad of recent changes, this is an inopportune time to engage in rulemaking, which would be better done after the industry has had time to settle down from the current changes (Robfegel, Chi II 233).

3. *Prospects for litigation.* A number of representatives of the industry contended that rulemaking will not reduce the amount of litigation, partly because it will still be unclear into what category various occupations fall (Rhodes, 14; Stickler, 49; Owley, 4379-80; Comment 213, Mulhall, AtlantiCare Medical Center); there will be continuing litigation over the "special situations" exception (Comment 148, Moeller, Mississippi Hosp. Assn.); and, in general, the industry anticipates more litigation rather than a conservation of agency resources (Stickler, letter dated June 19, 1987, RM 2-10; Comment 289, Ross).

C. *Opposing Position*

1. *Litigation.* Though the vast bulk of industry commentators opposed rulemaking, two did not oppose it. Thus, one hospital agreed with the observation that unit determinations in the industry were confused and hard to follow, deeming rulemaking a "welcome relief." (Comment 5, Kane, Holy Redeemer Health System.) Kaiser also does not oppose rulemaking, having observed protracted litigation elsewhere in the industry. (Comment 313, addendum to Kaiser comment.) One student with prior experience as a department head in several hospitals observed that rulemaking may help reduce costs in the industry, so that parties can spend fewer dollars on legal maneuvering and less time on organizing campaigns, leading to more industrial stability. (Comment 122, Shumlas.)

The unions participating in these proceedings supported the Board's rulemaking efforts. (ANA Br. 192-93; New York State Federation of Physicians and Dentists, 79-80; Health Professionals and Allied Employees of New Jersey (HPAE), 122, 127; Union of American Physicians and Dentists, 3649; SEIU, 5155; IUOE, Br. 106; IBT, Saporta, 5101.) They acknowledged the protracted litigation that had theretofore ensued (e.g., Saporta, 5141-42; HPAE, 122, 24; Minnesota Nurses Assoc., WS Patek; Federation of Nurses and Health Profs, WS Owley & 4379-80), producing lengthy delays and great difficulties in organizing (e.g., Lumpkin, 84-85; Nathan, 79-80; Union of American Physicians and Dentists, 3649). One management-side consultant is reported to have admitted that such delays were often part of management's strategy in contesting health care units:

At a workshop on unions, Raymond Mickus, president of Raymond F. Mickus & Associates in Bannockburn, Ill., predicted that the NLRB rules will spark much more union activity. . . . Under the rules there will be much, faster elections, he said, adding that employers won't have access to hearings or briefs which used to delay the proceedings * * *. There also will be less costs for the unions because they will not have to spend the "megabucks" associated with the hearing process, he said. (Current Developments, BNA Daily Labor Report, Aug. 6, 1987, p.A-2.)

Shortly thereafter, another health care industry representative is reported to have said something very similar: "Delaying representation elections. The greater the time between the initial union petition and the election the less chance there is that the union will win." (Metzger, vice

president of labor relations for Mount Sinai Medical Center, discussing management's strategy, though not necessarily advocating it himself. Reported in Current Developments, BNA Daily Labor Report. Sept. 29, 1987.)

2. *Diversity.* There is some variation between institutions. No two hospitals are exactly alike, but this is true of all institutions. The relevant question, however, is whether, despite surface differences, there are such similarities that certain institutions may properly be grouped as a class. AHA data from 1986 show that while there are a number of different types of health care providers, the overwhelming majority of private, acute care hospitals are general medical and surgical hospitals. Of the 4,381 registered, private acute care hospitals in the U.S., almost 90% are classified by AHA as general hospitals; less than 9% are classified as psychiatric. Of the general hospitals, 96% are medical and surgical hospitals, while only 2% are pediatric, obstetric, or rehabilitation hospitals. (AFL Exh. 7,8.) Inpatient activity accounts for 84% of hospital revenues, and 88% of inpatient beds are allocated to general medical and surgical care, obstetrics, pediatrics, and intensive care. (AFL Exh. 9,10.) The unions contend that the industry has not shown that such diversity as does exist is reflected in different functions for business office clericals, skilled maintenance employees, unskilled service workers, etc. at the different types of facilities.

The unions concede the presence of cost pressures which have changed the climate in which hospitals must operate today (AFL Br. 134; WS Berliner; Comment 293(i). Feldsine). However, they argue that change is endemic in the health care field, and contend that recent changes are not qualitatively different from changes brought about by

the advent of private health insurance or introduction of Medicare and Medicaid, equally profound and dramatic changes (Kennedy, 5549-50). As reflected in the testimony about particular job classifications. DRGs are an accounting and financing mechanism that has nothing to do with the organization of the hospital labor force, and that has not resulted in employees performing jobs that were traditionally performed by other groups of employees (Kennedy, 5551-53; Berliner, 5628-29). In fact, business office clerical's skills have been upgraded because of increased complexity of their work caused by financial pressures (Berliner, 5600). The unskilled workforce has become even less skilled and more vulnerable to layoffs caused by financial shortfalls (Berliner, 5603-04). Similarly, technical employee ranks have declined in the least skilled technical positions while increasing in the most skilled positions as a result of industry changes (WS Berliner at 11-12; WS Schoen at 14-15). Skilled maintenance employees continue to maintain the physical plant (AFL Br. 132). Neither has the role of RNs changed; they continue to provide direct care to patients and clients as in the past (ANA Br. 163).

3. *Changing Structure.* There was evidence that, at least in California, the trend toward consolidation of ownership and management of hospitals into multi-hospital organizations appears to have ended (AFL Exh. 17 at p.2, from California Assn. of Hospitals and Health Systems Report). Further, corporate mergers and larger organizational changes have not affected relationships between traditional job classifications; rather, the changes are in the corporate officers, locus, and method of corporate decision-making (Federation of Nurses and Health

Profs, WS Owley; Patek, Chi I 48; Twomey, 126-127). In any event, the proposed rule does not purport to address the issue of the appropriateness of a single facility, when an employer owns a number of facilities, which the Board will continue to address through adjudication. *Manor Healthcare Corp.*, 285 NLRB No. 31 (Aug. 6, 1987).

D. Conclusion

1. *Agency discretion.* The choice between deciding an issue through adjudication or APA rulemaking is, in the final analysis, within the informed discretion of an administrative agency. *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979). Here, we have carefully reconsidered our initial decision in light of all the evidence adduced at the hearings. After examining all this evidence, we remain convinced that rulemaking for establishing appropriate bargaining units in health care institutions is both fair and desirable. The record of these proceedings has supported and amplified our original reasons, set forth in our first NPR, for engaging in rulemaking.

2. *Past adjudicatory decisions.* Our adjudicatory decisions as to appropriate units in the health care industry, where the facts of each case were painstakingly examined in numerous lengthy and costly representation case proceedings, have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests. (NLRB

Exh. 5, revised.) Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings the Board found RN units appropriate in 24 out of 25 published cases;³ technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc. Though adjudication led to varying results for skilled maintenance units, that was largely a function of a single Board member, Member Jenkins, reaching different results on different records. Other members were, individually, remarkably uniform, despite alleged differences in the records. E.g., Member and Chairman Fanning found the separate maintenance unit appropriate 29 out of 29 times; Chairman Murphy, 26 out of 26 times. Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach. (See NPR, 52 FR 25143.)

3. *Financial constraints.* It cannot be denied that health care institutions are at this time operating under serious financial constraints. However, the evidence fails to disclose that these constraints have significantly changed the manner in which individual employee classifications perform their specialties or relate to one another. For example, the record shows that maintenance employees continue to maintain the physical facilities, and RNs continue to provide direct patient care under state nursing practice acts. If anything, the work of the

³ The sole exception was *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), involving a psychiatric hospital. In each category, unpublished cases exhibited the same uniformity of result.

business office clericals has been shown to have become more specialized and discrete, due to the increasing complexity of reimbursement arrangements, and also the increasing use of computers and word processing equipment. It is our judgment that the increased predictability which rulemaking will bring to the process of determining bargaining units will, in the long run, be a resource saver and, hence, result in cost savings not only for the Board but also for health care institutions as well as for employee organizations. Money expended on the *procedure* of determining appropriate units is not productively spent, except insofar as it leads to a greater understanding by the Board of realities of the workplace; we believe the understanding of the health care industry we have achieved through this rulemaking proceeding has been greater than it was through adjudication, where each party presented a very narrow view of the evidence in order to achieve victory in that particular case. Lastly, insofar as adjudication enabled employers to delay and in that sense save additional costs that might be associated with unionization, we do not think that is an appropriate factor to be considered by the Board in support of continuing adjudication.

4. *Diversity of institutions.* Just as this proceeding has not shown that new cost constraints have made rulemaking inappropriate, neither do we find that any new diversification of institutions has had this result. Such diversity as exists has not been shown to be sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate

bargaining units⁴ for acute care hospitals in all but truly extraordinary facilities. In fact, one witness, the Vice President of Human Resources, Hospital Council of Western Pennsylvania, testified that, even beyond acute care facilities, "the delivery of health care and the functional integration of services of those providing the care is similar if not nearly identical throughout the health care industry." (Cammarata, 4394). That same witness pointed out that this similarity in the way health care is delivered is "indeed mandated by various accreditation agencies throughout the health care field" (WS Cammarata at 3). The evidence discloses that the vast numbers of hospitals still perform acute care; insofar as other diverse facilities have developed, such as ambulatory facilities, freestanding emergency centers, etc., these will be considered *infra*, and in our definition of the types of facilities covered by this rulemaking or, alternatively, excluded. Recognizing the diversity of facilities other than acute care hospitals and nursing homes, as well as our limited experience with them, the original NPR excluded such other facilities from consideration in the rulemaking proceeding. These other health care facilities continue to be excluded from coverage.

5. *Litigation.* As described above, the Board anticipates that rulemaking will ultimately result in less, rather than more, litigation about the boundaries of appropriate units. It is acknowledged that there will still be litigation about the placement of individual job classifications within the broadly defined appropriate units. This was

⁴ See Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 9 (1987), at 105-108.

referred to in our initial NPR (52 NPR 25146), and in the proposed new rule itself (§ 103.30(a)); the Board does not see this as a reason not to engage in rulemaking in order first to establish the larger boundaries of the appropriate units. The Board believes it may well be legally necessary, and in any event is wise, to retain an exception for extraordinary circumstances. However, the Board intends to define that exception narrowly, so that it cannot be used as an excuse for unnecessary litigation and delay. See section XX, The Extraordinary Circumstance Exception, *infra*.

6. *Flexibility.* The Board's engaging in rulemaking has no logical connection with the industry's retention of complete flexibility in responding to the needs of the times. Rulemaking is rather a response to a perception that the industry's workforce is susceptible to rules of general applicability about the contours of bargaining units. Health care providers remain as free as they ever were to respond to external events except, of course, as limited by the constraints of any collective-bargaining obligations that may result from unionization; that, however, is a policy set by Congress, not the Board. If, for some reason we cannot now foresee, employers' flexibility to respond is inhibited, any party could, of course, petition for amendment or repeal of the rules, or the issuance of new rules. Board's Rules and Regulations, § 102.114.

7. *Other considerations.* Our colleague dissents and would not engage in rulemaking. However, were we to continue to decide the appropriateness of units in acute care hospitals solely by adjudication, we would not have the advantage of the great mass of evidence presented to

us in this rulemaking proceeding. Indeed, the production of relevant information is one of the chief advantages of rulemaking over adjudication. In addition, as noted above, adjudication itself has resulted in non-fact-sensitive, virtually uniform results, but at great cost in terms both of time and money. These problems, which we have observed in appropriate unit adjudications in this industry since the 1974 amendments, would not necessarily disappear, even were the Supreme Court to grant certiorari and endorse the "community of interests," "disparity of interests," or some other standard. Lengthy hearings would still be required, and the Supreme Court is unlikely to involve itself in particularized, detailed factual inquiries over various appropriate unit determinations. Finally, it is by no means certain that the Supreme Court would grant certiorari on this issue, having declined to do so in *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980). On another occasion, the Solicitor General refused to file petitions for certiorari, despite the Board's request that he do so, in *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982), and *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982). The court in the most recent relevant case, *IBEW, Local Union No. 474, AFL-CIO v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), remanded to the Board for further consideration, leaving any petition for certiorari susceptible to the argument that the court's disagreement with the Board's result was in any event not final.

III. Standard To Be Applied in Determining Appropriate Units

The Supreme Court has acknowledged on many occasions since the Act's passage that, under section 9, the

Board possesses broad discretion to determine employee units "appropriate" for the purposes of collective bargaining.⁵ Of course, even the Board's discretion is not without limits; if the Board's decision as to appropriate unit "oversteps the law," it must be reversed.⁶ Within this limit, however, the Supreme Court has noted that any decision as to appropriate units "involves of necessity a large measure of informed discretion, and the decision of the Board, if not final, is rarely to be disturbed."⁷

It has been observed that, in exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting

⁵ *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72 (1971); *NLRB v. Hearst Publications*, 322 U.S. 111, 132-35 (1944); *Pittsburgh Plate Glass Co. v. NLRB*, 313 U.S. 146 (1941); *Phelps Dodge Corp. v. NLRB*, 313 U.S. 177, 199 (1941). Not all administrative agencies engaged in regulating labor-management relations possess such broad unit-making discretion. Morris, *The Developing Labor Law*, Second Edition. 415 at fn. 12.

⁶ *Allied Chemical & Alkali Workers, supra*, 404 U.S. at 171-72.

⁷ *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947).

its constituency and hence its bargaining strength.⁸ The Board's goal is to find a middle-ground position, to allocate power between labor and management by "striking the balance" in the appropriate place, with units that are neither too large nor too small.⁹

As if this task, committed to the Board's discretion, were not already sufficiently difficult, in the health care field there may be, as one court has phrased it, a "joker in the deck."¹⁰ Much has been written, especially by reviewing courts, about the effect of the legislative history of the 1974 health care amendments on the Board's discretion to decide appropriate bargaining units. As the D.C. Circuit recently observed, in passing the 1974 amendments "Congress, in the final analysis, decided against modifying section 9 of the Act;¹¹ * * * hence, the same statutory standards that had existed before the enactment of the 1974 Amendments with respect to unit determinations and certification procedures remained in the statute, entirely unmodified."¹² Even the D.C. Circuit recognized,

⁸ See Gorman, *Basic Text on Labor Law*, 66-69 (1976); Abodeely *et al.*, *The NLRB and the Appropriate Bargaining Unit* 12-13 (rev. ed. 1981); *NLRB v. Hillview Health Care Center*, 705 F.2d 1461, 1469-70 (7th Cir. 1983).

⁹ *NLRB v. Hillview Health Care Center*, 705 F.2d at 1469.

¹⁰ *Id.*

¹¹ *IBEW, Local Union No. 4 v. AFL-CIO v. NLRB*, 814 F.2d 897, 899 (D.C. Cir. 1987).

¹² *Id.* at 701. The Supreme Court in *Packard*, *supra*, declined in that case to look at legislative history regarding whether "foremen" could appropriately constitute a bargaining unit, noting that "we are invited to make a lengthy examination of

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though, that other Courts had disagreed.¹³ Two Circuits¹⁴ have required the Board to apply a "disparity of interests" test, based largely on the legislative history, while eight others¹⁵ have made it clear the Board should follow the committee's admonition to give "due consideration * * * to preventing proliferation of bargaining units in the health care industry," though they fail to "dictate the precise weight to be accorded the admonition."¹⁶ We believe that rulemaking renders it unnecessary to resolve this conflict, or pick one doctrinal formulation over the other, since rulemaking eschews doctrinal applications in favor of greatly expanded information gathering, to be followed by unit determinations based on empirical judgments of the type that Congress expected an expert, informed administrative body to make.¹⁷

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views expressed in Congress while this and later legislation was pending to show that exclusion of foreman was intended. There is, however, no ambiguity in this Act to be clarified by resort to legislative history * * * ." *Id.* 330 U.S. at 492.

¹³ 814 F.2d at 704.

¹⁴ The Ninth and Tenth. See discussion by concurring Judge Buckley in *IBEW Local Union 474 v. NLRB*, 814 F.2d at 717.

¹⁵ The Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, and Eleventh. See cases cited *id.* at 703-06.

¹⁶ *Id.* at 717.

¹⁷ See, e.g., Estreicher, *Policy Oscillation at the Labor Board: A Plea for Rulemaking*, in proceedings of NYU Annual National Conference on Labor (1964), reprinted in 37 *Ad. L. Rev.* 163, 172 (1985).

Under adjudication the Board has typically stated it was applying either the "community of interests" or "disparity of interests" standard to the facts of the particular case, as indicated reaching virtually the same result in every case, depending on which doctrine was being applied (NLRB Exh. 5, revised). Under the "community of interests" test, the Board has found five or six units appropriate (not including a statutorily-required separate unit of guards, seldom if ever sought, and a separate unit of physicians, sought in only one published decision since 1974¹⁸): RNs, other professionals, technicals, service and maintenance, and business office clericals. In addition, some individual Board members have consistently found skilled maintenance units appropriate; others consistently found them inappropriate. (NLRB Exhibit 5, revised.) Under the "disparity of interests" test, the Board has uniformly found three units appropriate, aside from the two seldom-sought units mentioned above: All professional employees, including RNs; technical employees; and service and maintenance employees, including business office clericals.

Though it had consistently reached different results under the two tests, the Board in *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), minimized the conceptual difference between them. Both, the Board stated, looked at the same factors:

¹⁸ *Ohio Valley Hospital Assn.*, 230 NLRB 604 (1977). See also *Montefiore Hospital & Medical Center*, 235 NLRB 241 (1978), where a separate unit of physicians and dentists was found appropriate, but largely because there were no other professionals employed at the employer's health center, which was deemed to constitute a separate appropriate location.

* * * the "disparity-of-interests" standard to a significant extent embodies the "community-of-interests" approach. That is, even under the disparity approach, the Board judges the appropriateness of the unit sought in terms of, traditional community-of-interests criteria: employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contacts and extent of interchange with each other; frequency of transfers into and out of the unit sought; common supervision; degree of functional integration; collective-bargaining history; and area bargaining patterns and practices. Under the "disparity-of-interests" standard - as under the "community-of-interest" approach - the Board looks at the above factors as they are shared by employees in the unit petitioned for, and as they tend to set those employees apart from other employees. Where the "disparity-of-interests" formulation differs from the "community-of-interests" standard, according to the Board's *St. Francis II* decision, is in the significance afforded the above factors. Because of Congress admonition to avoid unit fragmentation, the "disparity-of-interests" test requires more in the way of "disparities" or differences between the employees requested and those in an overall unit to grant a separate unit in the health care industry than would be required under a "community-of-interests" formulation. (Slip op. at 10-11, footnotes deleted.)

It is difficult to weigh or quantify the requirement of "more" as it applies to separate, different interests, i.e., how much would be enough more to satisfy the "disparities" test? Regardless, as we observed in the NPR, "these tests over the past decade or so have developed a 'life of their own,' and have been taken to refer to more or

fewer units, respectively * * * ." (52 FR 25143.) As the Board stated in *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), various courts' "disagreement with our approach may be largely semantic." And, as the Second Circuit said in *Masonic Hall v. NLRB*, 699 F.2d 626, 637 (1983), a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account." The court suggested that perhaps courts "focus * * * on what the Board did as much on what it said." *Id.* As noted in the NPR (52 FR at 25143), and in our discussion above, our decision to determine units by rulemaking reflected a desire to replace earlier doctrinal applications with formulations of units based on the facts, or realities, of the workplace, as learned from evidence presented to the Board by interested parties during the rulemaking proceedings.

Under rulemaking as under adjudication, we intend at all times to be mindful of avoiding undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry. It would be most undesirable to create or permit a large-scale splintering of the workforce into the numerous trades, technical disciplines, and professions typically found in health care institutions.¹⁹ To give each such

¹⁹ As Abodeely notes, "the health care industry was believed to be particularly vulnerable to the formation of a multiplicity of bargaining units. From the doctors in the top echelon to pot washers on the bottom, the labor force of a large health care facility is composed of a highly stratified, complex myriad of occupational classifications." This was, Abodeely

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grouping a separate voice for organizing and negotiating would create a never-ending round of bargaining sessions and individualized demands not conducive to stability, industrial peace, or the smooth delivery of services to the public. We have entered the rulemaking endeavor with an intention to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. We have not begun with a preordained number, but at the end of our examination will consider whether the numbers of units found appropriate are, in fact, too numerous. See section XXI, Proliferation, *infra*. In any event, there will be no units found appropriate besides those permitted in the final rule.

Although under rulemaking we shall attempt to avoid the doctrinal formulations utilized under adjudication, many of the factors we consider will be similar. Thus, among the factors to be considered will be uniqueness of function; training, education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective

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states, the purpose behind the proliferation language referred to in the legislative history. Abodeely, *supra*, at 245. See also *NLRB v. Hillview Health Care Center*, 765 F.2d at 1470.

bargaining, such as bargaining history, matters of special concern, etc. Location and scope of the job market may be relevant: i.e., whether the classification is part of a job market external to the facility or even to health care, or rather shares a job market with others in the facility or, perhaps, in the areawide health care community; job market is a factor not extensively considered under adjudication, probably because evidence regarding it is not likely to be introduced during the litigation of a particular case. In addition to these factors, should the evidence reveal the possibility of a separate unit, we shall examine the likelihood that such a separate unit would result in interruption in the delivery of health care, wage whipsawing, or jurisdictional disputes, matters with which Congress expressed concern during the deliberations that preceded the 1974 amendments. (See, e.g., 52 FR 25145; *St. Francis Hospital (St. Francis I)*, 265 NLRB 1025, 1027, 1035 (1982) (dissent, Chairman Van de Water); but cf. *Manor Healthcare Corp.*, 285 NLRB No. 1, n.7 (Aug. 6, 1987).)²⁰ The

²⁰ Senator Taft, in opening the Congressional debate on the health care amendments, said: "The issue of proliferation of bargaining units in health care institutions has also greatly concerned me. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. . . . I believe this is a sound approach and a constructive compromise as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in

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emphasis, during our rulemaking deliberations, has been and will be on the empirical – what, according to the mass of evidence presented, is warranted and will facilitate collective bargaining without jeopardizing the public interest – as opposed to prior, more doctrinal, more conceptually oriented, determinations. We are confident we are now a better informed administrative body in exercising the substantial discretion which we possess in the area of unit determinations.

IV. Two Units: All Professionals/All Non-Professionals

Some members of the hospital industry have argued to us that if the Board engages in rulemaking, it should find only two units appropriate – all professional and all non-professional employees (in addition to guards). Upon consideration of the record, we determine that the evidence does not warrant limiting the number of units to two broad units.

A. Generally; History of the 1974 Amendments

While the industry generally supports two broad units of employees, the support is not universal. Some employers suggest other configurations including a wall-to-wall unit, a separate doctors' unit, and a separate

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this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented." *Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act*, at 113-14.

technical unit. (Comment 1, Lancaster Fairfield Community Hospital; Comment 17, Middletown Regional Hospital; Comment 306, Herrin, attorney for health care associations.) Indeed, one employer felt that several separate units was equitable as each had its own characteristics. (Comment 2, Grays Harbor Community Hosp.) The position of some, in favor of two units, is inconsistent with evidence which shows that until *St. Francis II*, employers seldom requested all-professional or all non-professional units (Friedman, 5057), and that where employers did request broad units for elections they sometimes opposed such units during election campaigns or at the bargaining table (see Registered Nurses, section V). On the other hand, unions fully support more than two broad units for organizing (AFL Br. 112; IUOE Br. 8; Local 1199, 3742; FNHP, 3; UFCW, 4457; NUHHCE, 4778; IBT, 5100; SEIU, 5161). These unions' position is consistent with the evidence presented of organizing history (see section V, Registered Nurses; section IX, Skilled Maintenance; section X, Business Office Clericals; etc.).

Contrary to some employers' claim that the legislative history of the hospital amendments supports a two-unit configuration, the history shows that Congress chose not to amend section 9(b) (assuring employees the fullest freedom in exercising rights guaranteed by the Act) in a way that would enact special representation case rules for the health care industry. Even Senator Taft's proposal, which embodied the proposal advanced by employer associations in the health care industry but which died in committee, contained special rules established as presumptively appropriate three non-professional units (technical, clerical, service and maintenance), in addition

to a professional unit and guards, for a total of five. Furthermore, the hospital industry agreed, in a negotiated compromise with organized labor, to abandon its request for special statutory rules limiting the number of hospital units in return for provisions governing strikes. (See Legislative History, *supra*, at 91 (Sen. Cranston); 256 (Sen. Taft); 288 (Rep. Thompson), cited in AFL Br. 18-27.) The arguments of many employers that all professionals interact on the job, and that there are insufficient distinctions between classifications of non-professional employees to warrant their separation into different units, and the unions' argument that the record supports separate associational interests, are dealt with under specific unit categories.

B. The Record Shows That Multiple Units Do Not Undermine Functional Integration of Work; Do Not Result in an Increase in Proliferation, Strikes, Jurisdictional Disputes, or Wage Whipsawing; and Do Not Substantially Increase Industry Costs

The industry's concerns with having more than two units are the following:

1. *Changes in the industry.* The industry has failed to support its claim by concrete evidence that the DRG method of government payments to hospitals has resulted in restructuring of hospital workforces away from traditional departments and toward a product-line organization that requires greater integration of employee functions. It is claimed that product line management (where different types of employees work in a service related group, for example cardiology) is used increasingly in hospitals and requires that traditional

lines of employment be crossed to provide appropriate patient care as employees in a department cooperate (Abramovitz, 325; Comment 54, Gepford Hosp.; Comment 192, Chicago Healthcare Human Resources Assn; Comment 108, Resurrection Health Care Corp.). However, the evidence shows that product line management has less to do with actual practice on the wards than it does with financial operations performed in the business office (WS Kennedy at 6-7). There is no more interaction between professionals than under other forms of financial control. New financial requirements have not resulted in changes in interaction among hospital workers. (WS Kennedy at 6-7.) Even in hospitals where RNs and other professionals are subject to dual lines of control (combining authority under own licensure and under team or functional department), RNs continue to report to nursing on clinical issues, and retain traditional responsibility for nursing (Comment 293(i), Feldsine; Thompson, Chi II 107; Kennedy, 5561; Fine, 3146-48). Contrary to the generalized claim (Comment 105, Mass. Hospital Assn.) that multiple units would be divisive since one department might contain employees from several units, specific evidence shows that separate units have not prevented effective use of product line management (Houston, 4031, 4048).

In arguing that hospital workforces have moved away from a traditional structure, the industry relies heavily on the team concept, claiming that its use has resulted in greater integration among employees requiring integration of units (Rhodes, 11-12). However, the team concept dates back many years in this industry

(AFL Exh. 12, 13, 14; AMA, 4348). Hospital representatives relied on the existence of teams in their unsuccessful attempt to defeat the 1974 amendments (ANA Br. 126). The record does not demonstrate a substantial increase in the use of interdisciplinary teams since then (AFL Exh. 15, study by Temkin-Grenner; WS Kennedy at 8-9).

Although the industry argued that the team approach is widespread in the country and gave examples of many types of teams such as discharge planning, and special unit teams like oncology, diabetes, and cardiac rehabilitation (Mixon, Chi II 275; Gallagher, 3543-45; Comment 191, Trinity Lutheran Hosp.), the weight of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals (Bachus, Chi I 132; Lumpkin, 89-90; Dauner, 3236-40; McCullough, 4819-20; Gilmore, 4910). A study of 60 randomly selected hospitals showed fewer than half used discharge planning teams; a minority of the hospitals had special unit teams such as diabetes, oncology, and cardiac rehabilitation (Attachment to AFL Br. from Supplemental Testimony of L. Kennedy). Some hospitals do not utilize the team concept at all (Gilmore, 4910). Most hospitals with teams have no more than six or seven teams, with two to eight members on a team (Coney, 162; Thompson, Chi II 14-15, 72; Mixon, Chi II 277, 294-296), and a majority of employees do not participate on those teams (Bachus, Chi I 129-132). Specialized hospitals, such as children's hospitals, which may use multi-disciplinary teams to a greater extent, are atypical (AFL Br. 104).

The evidence does not support the industry's claim that participation on teams changes the employee's role. Collaboration among professionals is not new (Ballard,

56). For example, one of the most common teams is discharge planning which historically involves nursing and social work. But the team approach does not alter each licensed professional's responsibilities or scope of practice (Ballard, 56; Willman, 4461; Twomey, 131). For example, use of physicians, assistants and nurse practitioners does not alter physicians, scope of practice. Nor does participation on a team affect an employee's wages, hours of work, employment benefits, qualifications, training, skills, job functions, or history of bargaining (AFL Br. 104-105; Graybill, 4174-75; Houston, 4044-45). Where teams are used, only a small proportion of the professional employees are involved. Contact between the members of the team is limited; each member continues to perform the specialized work of his or her profession. The time spent on a team is limited: team members may perform their work separately and then exchange information; team members are not likely to engage in more than fleeting communication regarding collective bargaining matters. (Thompson, Chi II 107, 109, 118-119, 121; and see section V, Registered Nurses, *infra*.) Recognition by the Joint Commission on Accreditation of Hospitals (JCAH) of the need for collaboration on the interdisciplinary level (AHA Br. 16 citing JCAH sec.) does not itself demonstrate that any change in scope of practice occurs.

There is evidence that various employees interact on hospital committees to evaluate hospital programs, but the evidence failed to demonstrate that the interaction affects the professionals' responsibilities or scope of practice (see, e.g., AHA Position Statement p. 8).

The industry made general, unsupported claims that separate units would interfere with the development or

use of the team approach (Graybill-Subrin colloquy, 4185-86; Donnelly, 4131; Coney, 162). There is no evidence that separate units have resulted in failure of professional integration and cooperation on teams (ANA Br. 139; Bullough, 4651-53). On the contrary, teams were shown to be compatible with presence of RN-only units (ANA Br. 123; Thompson, Chi II 86-87; Houston 4048; Bullough, 4651-52).

The industry's emphasis on teams and product lines focused almost exclusively on professional employees. There was no claim that these teams brought technical employees and unskilled service employees together in a single group. Nor was it claimed that business office clericals were involved in health care teams. (AFL Br. 75.) The evidence shows that interdisciplinary teams do not include skilled maintenance employees (IUOE Br. 92; Mixon, Chi II 275).

The industry contends that the use of multi-skilled employees is widespread and on the increase as hospitals seek cost-cutting measures, address the needs of rural hospitals with limited full time staffing needs and large facilities with changing patient loads, and as employee shortages, aging and declining population lead to fewer workers; further, that adoption of the proposed units will abrogate the ability of facilities to effectively utilize multi-trained employees whose skills cut across unit lines (AHA Br. 8, 9; AHA Br. attachment 3 attaching survey by CAHEA; Rhodes, 11; Houston, 4025-26, 4040-42; Comment 137, McDonough District Hospital; Comment 189, Memorial Health System, Inc.; Comment 193, Dolly Vincent Memorial Hospital). However, the evidence shows that cross-training *between job groups* was not substantial

and did not result in blurring lines between separate units. There are no examples of any group of professionals being cross trained to perform work of RNs either in organized or unorganized settings (Stickler, 22-25; Twomey, 130-131). The interchange of RN functions is not a viable concept because state licensing statutes preclude cross-training of other health professionals in patient care duties and responsibilities of RNs (Ballard, 56-57; Dumpel, 3277-78; Lipari, 3702-03; Rosen, 4665-67; Comment 293(j), paper on licensure of health care personnel).

The evidence shows that multi-competency programs are overwhelmingly aimed at technical employees. They developed because of a perceived need to provide technicians with a broader range of technician skills (WS Schoen, attaching article by F. Morgan). These programs are mainly confined to acquisition of additional technical skills by employees already holding technical jobs as shown by the operation of the programs referred to in the record. Participants in the Methodist Hospital "Add-A-Comp" program which provides employees with laboratory, respiratory therapy, electrocardiograph, emergency medical technician, and similar skills are already licensed or credentialed and include employees having some of the listed skills (Stickler, 19-21 & Chi I 36). Although the Multi-Competency Technical Program at the University of Alabama provides training in medical office skills, it is basically designed to add basic x-ray skills or extend laboratory skills for technicians who are already licensed (Stickler, 19-21, Chi I 36-38). There is no showing that students trained in medical office skills actually perform technical tasks. Furthermore, the mere

existence of the program does not show widespread participation, since the record fails to show there are many students involved (Stickler, Chi I 38-39). Moreover, even if these programs turn out a number of multi-competent graduates, they are generally employed in physicians' offices or outpatient facilities rather than in hospitals (Schoen, 5236 and WS Schoen, attaching article by F. Morgan) and their use therefore has little relevance to units in acute care hospitals.

We conclude from the record evidence that cross-training programs extending beyond the technical workforce are rare. Unskilled service workers cannot be readily trained to become technical employees because they lack the advanced education required and because of state licensure laws (AFL Br. 35-36; IUOE Br. 42, fn 5). Service workers cannot be easily trained for business office clerical jobs because of the specialized skills required in the business office (AFL Br. 57-58). Cross training from service to skilled maintenance or technical positions is virtually unknown (O'Cleireacain, 5467; McKinney, 5481). Business office clericals do not transfer into skilled maintenance positions (IUOE Br. 42). Nor are skilled maintenance employees being cross-trained into other job groups (Stickler, Chi I 9, 35-37). The few examples of individuals having interchange of functions (emergency technician starting IVs, RNs doing work after daytime hours normally performed by respiratory therapist or physical therapist, medical technologist trained to watch the heart monitor while RN is on break - Houston, 4026-27, 4042) are very limited. Evidence does show that separate RN units are compatible with limited interchange of function (ANA Br. 153, citing Houston, 4040).

There is no evidence to support the industry's general claim that cross-training has been inhibited by collective bargaining in separate units (ANA Br. 151; IUOE Br. 45; Stickler 45-49). The suggestion (Comment 142, St. Anthony's Health Corp.) that use of multi-competent workers would be hurt by turf battles between professional groups, separate bargaining unit designations, and existing legal restrictions on practice patterns is speculative and is undercut by finding that most multi-competent workers are within one unit – the technical unit. Any problems raised by legal restrictions such as licensure requirements do not derive from the Board's proposal to allow multiple units. Industry testimony on interchange of functions between professionals and non-professionals (Donnelly, 4073-74; AHA Br. 11) is not relevant because the Act would not permit a unit combining professionals with non-professionals, absent a self-determination election by the professionals.

Countering the claim of increasing integration of health care employees is evidence of increasing fragmentation as a result of greater sophistication of work, decrease in the full time equivalent work force and rise in part-time and temporary jobs, increase in the use of subcontracting, growing gaps between patient care and non-patient care jobs (such as business office clericals), and growing gaps between RNs and other professionals because of the RN shortage (WS Schoen).

2. *Proliferation, strikes, jurisdictional disputes, and wage whipsawing.* There is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation such as strikes, jurisdictional disputes, and wage whipsawing.

First, the record shows that most hospitals that are organized have few units (Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4424-4425). Logically, the potential for a number of units does not mean that every hospital will be faced with this number of organizing campaigns. Indeed, a successful organizing effort of one unit in a hospital does not appear to have had a ripple effect on further organization (Gilmore, 4894; Splain, 5252-53; IUOE Br. 69-70). Statistics over the last ten years show little organizing in residual units. Health care workers organize no more frequently in facilities where some workers are already engaging in collective bargaining than in facilities where no employees are represented (WS Splain at 14-17). A vast number of organized hospitals have only one unit (WS Schwartz at Table 1 & 264; Sockell, 4520; Shea, 5163). AFL analysis of all hospital contract renewal notices received by the FMCS from hospitals from 1983 to 1987 shows that 55% of all organized hospitals are party to only one collective-bargaining agreement; almost 80% negotiate no more than two contracts; and almost 90% negotiate no more than three contracts (AFL Exh. 5 p. 1). In an SEIU survey of 200 private hospitals, 74% have 3 or fewer bargaining units (WS Shea, SEIU, Table 2).

Evidence shows that, with the exception of New York State, where pre-1974 practice was to permit each employee group to have its own unit, recognition of RN-only units has not led to organizing efforts by other professionals (King, Chi II 38: In Ohio there is only one unit in which professionals other than RNs are represented separately; Gilmore, 4894: No hospital represented by Maine State Nurses' Association has another

professional unit in addition to RN unit). Existence of a physicians' unit is rare; some states, like Texas, do not permit physicians to be employees of health care facilities (IUOE Br. 64, 99; see section VI, Physicians, *infra*). There is no evidence that the existence of a separate skilled maintenance unit has led to the organization of other units (IUOE Br. 62-65 and section IX, Skilled Maintenance, *infra*).

Some witnesses' statements that multiple units lead to strikes, jurisdictional disputes, and wage whipsawing were, for the most part, general and speculative, and not supported by examples. See, for example, Graumann, 397, 409; Dauner, 3199; Corbett, 3369; Emanuel, 3503-04; Weinrich, 4254, 4256; Cammarata, 4403, 4405-06. The industry did not submit data with respect to the degree of organization, number of organized units per hospital, or incidence of strikes or sympathy strikes, nor evidence that a particular type of unit has proven to be strike prone (AFL Br. 118-19).

In fact, the evidence submitted by unions shows there is a low incidence of strike activity in the health care industry; the rate is lower than in other industries (IUOE Br. 75; NLRB Exh. 1; AFL Exh. 6). The ANA had a voluntary no-strike policy until 1968 (Shepard, 4931-32). The California Nurses' Association (CNA) offers binding arbitration (WS Absalom at 16). According to available data, only 3.3% of all contract negotiations, including nurse bargaining, resulted in strikes. From 1984-1987, strikes in the health care industry occurred substantially less often than in all other industries (FMCS data reprinted in WS Schoen at 28 and AFL Exh. 6). The minimal level of strike activity is confirmed by studies

done by several health care unions. Since 1938, SEIU has had a strike incidence of 1.4% in over 2700 hospital contracts (WS Shea at 10). Of over 1,000 hospital contracts negotiated since 1975 by the NUHHCE, only 43 involved strikes (Muehlenkamp, 4776). IUOE, which represents almost 300 hospital bargaining units, has had only 25 strikes in its history (IUOE revised Exh. 2).

Industry witnesses who testified about collective bargaining experiences in the industry confirmed the infrequency of strikes (Comer, Chi II 320; Corbett, 3374-75; Henry, 3026, 3062, 3085-86). Indeed, Kaiser specifically stated that its observation that there is a greater likelihood of work stoppages in facilities with multiple units was limited to craft-specific units, not the broader, traditional unit groupings (Comment 311). The industry's claim that the Board should discount the lack of strike activity in professional units because few facilities have multiple units supports our finding that in fact few facilities have multiple units.

One study showed there is generally no correlation between the number of units in a hospital and the frequency of strikes (AFL Br. 118, fn citing FMCS study). Other evidence suggests, however, that the likelihood of strikes decreases as the number of units in a hospital increases (IUOE Exh. 2 revised). Strikes also tend to occur more frequently in units with more employees than in smaller units (AFL Exh. 5). For example, only 16.4% of hospital contracts covered 300 or more employees, yet these units account for 45.5% of all strikes, while 51.52% of all hospital contracts covered 100 or fewer employees, but accounted for only 17.7% of all strikes. The average size of a striking unit in the 1984-87 period was three

times the size of a non-striking unit. (AFL Exh. 5 citing FMCS data.) See also WS Shea at 11-12 with similar variation in size of striking SEIU units. Strikes in broader units have the greatest impact on health care. Strikes in New York City by Local 1199 encompassing many worker classifications including other professionals, technicals, service, and clericals closed down most health care in the city. (Abelow, 229.) Strikes in broader units also draw in groups of employees who, if in their own smaller unit, might have no reason to strike (Dumpel, 3291: Strike over nurse practice issues would have no importance to other groups of employees; Viat, 3466; Shea, 5188: Skilled maintenance employees, technical employees enmeshed in strikes over issues related to other groups of employees).

The evidence shows that sympathy strikes are virtually nonexistent. No-strike clauses in hospital contracts forbid sympathy strikes, and the pattern in the industry is for covered employees to obey their contracts. (Schloop, Chi II 169; Sackman, 3585; Ahmed, 3708-09; Muehlenkamp, 4777.)

We cannot accept the argument that multiple strike notices alone, even absent actual strikes, are disruptive, since the purpose of the notice is to minimize possible disruptive impact by giving hospitals time to prepare for a strike. In any event, there was no showing of widespread frequency of strike notices and no evidence that notices caused disruption in health care delivery. Hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes. (Sackman, 3586; Schmidt, 3625; Willman,

4496; Muehlenkamp, 4771; Henry, 3074-75; Corbett, 3359-60; Weinrich, 4282).

Some hospitals' argument that they do not have the same defensive measures as do employers in other industries, for example, because it is difficult to replace striking professionals, is essentially an argument that hospital employees not be allowed to exercise their statutory right to strike. The record does not show in any event that they engage in strikes frequently.

Industry's general claim (AHA Br. 26-27) that multiple units will inevitably result in jurisdictional disputes is not supported by the record. The record shows a low frequency of jurisdictional disputes in hospitals and no correlation between the occurrence of disputes and the number of units. Jurisdictional issues that have arisen are often resolved on an informal basis without resorting to arbitration (Absalom, 3282-83; Sackman, 3585; Schmidt, 3625; Viat, 3471; IUOE Br. 78-79). There was no record evidence of jurisdictional disputes in hospitals between units of professional employees (Emanuel, 3503-4); such disputes are usually fought and resolved in the public arena (Absalom, 3282). Jurisdictional disputes between non-professional groups are rare, apparently because traditional unit lines separate functional groupings and the unit employees do not view the other units' duties as being within their purview (AFL Br. 124¹-25). The few disputes specifically referred to by the industry, such as accusations of mistakes on the job, and conflict between duties of RNs and LPNs assigned by the hospital (Krasovec, 413-415; Giblin, 5389-90; Graumann, 396-399, 408), encompassed disagreements that could arise even under all-professional and all non-professional units. The

approval of an overall skilled maintenance unit, *infra*, should help reduce the risk of jurisdictional disputes between different skilled crafts.

The industry failed to support its general contention (Rhodes, 13) that multiple units result in employees' competing for the best settlement, burdening negotiations, and inflating settlements. The record shows that wage whipsawing and leapfrogging rarely, if ever, occur in the hospital industry. This is apparently the result of separate labor markets for RNs, clericals, technicals, skilled maintenance, and doctors (ANA Br. 174; AFL Br. 37-38, 59-60, 86-88, 121-22; IUOE Br. 83 citing record), and the method of setting Medicare and Medicaid rates which limits the pass-through of spiralling wage increases (Friedman, 5044-45). In view of the unorganized nature of the health care industry as a whole, separate unit contracts tend to follow wage patterns set by non-union employers (WS Shea at 13).

3. *Costs.* Some unions question the relevance of costs in determining hospital bargaining units. In view of Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services, it is relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions. However, to the extent the industry's contention regarding costs is an argument that employers cannot afford collective bargaining with their employees, we note that the health care amendments were passed in response to Congress' concern with low wages and poor working conditions in the hospital industry. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497 (1978). It was anticipated by Congress that the

amendments might lead to increased union organizing and bargaining which in turn might improve employee wages and working conditions. Costs associated with these anticipated improvements are not relevant to the Board's decision as to appropriate bargaining units.

Some commentators claimed that multiple units would increase costs by increasing expenses for contract negotiations, wage and benefit increases, administration and legal fees, grievances, supervision, and accounting (Comment 62, St. Mary's Hosp.; Comment 153, Sturdy Memorial Hosp.; Comment 140, Park City Hosp.; Comment 130, St. Vincent's Hosp., Birmingham; Comment 224, St. Luke's/Roosevelt; Comment 311, Hosp. Council of Southern Calif.). There was no empirical or specific evidence showing comparative labor costs in hospitals with different numbers of units. For example, one witness stated that facilities in Ohio with three or more units devoted more time and resources to collective bargaining than hospitals with fewer units, but had no specific examples (Weimer, Chi II 7, 65-66, 77-79). Another industry witness testified generally that increased costs were associated with negotiating in multiple units in Pennsylvania, but gave no specifics (Camarata, Hosp. Council of W. Pa., 4392-4430). In fact, studies have found minimal cost impact, 3%-5%, of labor unions on hospital costs. This rate is low when contrasted with the overall rate of health care cost inflation (WS Schoen at 31). The example relating to the costs for negotiations at a public hospital in Massachusetts with eight bargaining units (Robfogel, Chi II 222-23, 228, where out-of-state as well as local attorneys appeared for each negotiating session) was not shown to be typical.

The industry contends that small hospitals are particularly vulnerable to increased costs and cannot afford the money and staff resources needed for dealing with multiple units. However, we were not provided with empirical data for comparison. We note also that few health care facilities have more than two or three units.

The industry's claim that hospitals generally treat each bargaining unit as a separate cost accounting center, thereby adding to the complexity of operating a hospital, is unsupported in the record (Dauner, 3233-34), and in any event is irrelevant.

One witness claimed that multiple units would limit an employer's ability to secure significant cost reductions in employee benefits available now by marketing large groups of employees to third party providers and that the cost of administering multiple employee benefit plans is higher. No specific examples were cited of increased costs (Cammarata, 4402-03). Moreover, benefits may be negotiated across-the-board even in multiple units (Jacquin, 5366-68).

The claim by some that multiple units will result in limiting opportunities for job advancement and security are not supported by the record; neither is the claim that multiple units hamper affirmative action because departmental seniority and separate bargaining deter hiring and career development. To the contrary, there is record evidence (set forth in Sec. V, Registered Nurses and other sections), that there is limited career movement in hospitals regardless of whether or not the hospital is organized because promotions, layoffs, etc. are done by department and because of the distinct skills and education of the

various groups of employees which restrict interchange and mobility. There is also evidence that in organized facilities, unions have sought career ladders, training, and upgrading, and have not acted to limit movement among workers. (WS Schoen at 15; Supplemental Statement of Schoen.)

Some employers argue that multiple contracts limit their flexibility in job assignments, scheduling, and performance evaluation. This appears to be an argument that the industry does not wish to have to bargain since bargaining limits the employer's flexibility. However, the statute gives employees the right to bargain for more favorable terms of employment, and employers have the opportunity at the bargaining table to seek terms giving them flexibility.

Arguments that multiple contracts will result in confusion for management as to which contract covers which employees (Comment 104, St. Francis Hosp., Hartford), that it would be hard for employees to understand and deal with many units (Comment 51, O'Brien Memorial Hosp.), and that multiple units work against cohesiveness among smaller groups like business office clericals (Comment 138, Rice Memorial Hosp.) were not supported by specific examples.

Finally, the record demonstrates some countervailing considerations to any increased costs as a result of multiple units. At least some of the administrative costs of unit determinations come from the hospitals' opposition to organizing. In 1981, Congress banned the use of Medicare funds for anti-union consultants on estimates that this activity cost \$30 million dollars a year (WS Shea at 15,

citing Medicare Manual). There are presently industry costs for prolonged hearings and appeals in many units, which we are confident rulemaking will substantially reduce. Bargaining in large units may prolong negotiations and increase costs as employees are involved who would otherwise have no interest in certain demands (WS Shea at 15). Employers can face increased costs even if there is only one unit, since there may be separate negotiations for different major employee classifications (Owley, 4375-76) or separate contract provisions (Emanuel, 3499-3501). Costs might be contained by combining separate units for bargaining purposes or having common expiration dates for contracts, but the record shows lack of employer support for such union proposals (See Sec. IV(B)(2), *supra*).

C. *Broad Units Militate Against Health Care Employees, Organizing and Bargaining, Contrary to Congress' Intent*

1. *The impact of broad units on organizing and bargaining is a relevant consideration.* As shown above, Congress passed the health care amendments, in part, to improve conditions for health care industry employees by extending to them the rights of the National Labor Relations Act which permits organizing and collective bargaining. *Masonic Hall v. N.L.R.B.*, *supra*, 699 F.2d at 634. While, as the industry correctly contends, the extent of union organization cannot be controlling in unit determinations, it is a factor, and in view of Congress' concerns, the ability of health care employees to organize and bargain is an important consideration in determining whether more than two units are appropriate in the industry.

2. *Historically, health care workers organize and engage in initial bargaining in occupationally homogeneous units.* The evidence shows that broad units militate against organizing by health care workers (AFL Exh. 4, AHA Report on Union Activity in the Health Care Industry). Although there were examples of broad-based bargaining, particularly in New York City, the record shows that organizing and initial bargaining among health care workers has historically been by occupationally-homogeneous units (AFL Appendix A; WS Shea, Table 1, SEIU Survey; and section V, Registered Nurses; section VI, Physicians; and section VII, Other Professionals). For example, in the AFL survey of all private sector hospitals in which an AFL affiliate has organized one or more units, there were 920 homogeneous non-professional units, and only 104 heterogeneous units (AFL Br. Appendix A). The ANA constituent state nurses' associations represent 363 all-RN bargaining units; only 4 all-professional units were organized before *St. Francis II* (Comment 240, ANA, Stull Affidavit). Evidence prepared by the industry confirmed that occupationally diverse bargaining units are found only in a minority of contracts (AFL Exh. 1, [Hospital Industrial Relations Informational Services, p. 5]).

The industry contends that unions have requested or agreed to all-professional and all non-professional units, have successfully organized and bargained in these units, and that therefore a Board decision to find appropriate only two broad units (plus guards) would not negatively impact on organizing and bargaining. The record shows that most union requests for broad-based units occurred after *St. Francis II*, at a time when the Board would have rejected most occupationally-homogeneous units. Broad

bargaining, where it does occur, appears to develop over time, after individual employee unit concerns are addressed and the bargaining relationship has matured (WS Shea at 8; WS Pastreich; Friedman, 5046). Even then, the record shows that employers may meet separately with one or more subunits on their concerns and that there may be separate contract provisions for different concerns. See *e.g.* section VIII, Technicals; section X, Business Office Clericals. Thus, in New York City, where Local 1199 engages in citywide bargaining with the League of Voluntary Hospitals on behalf of its Professional, Technical, and Clerical Division (professionals other than RNs), Hospital Division (service and maintenance employees) and Drug Division (pharmacists, social workers, therapists), the individual units in these divisions were separately organized and negotiated their first contracts separately; joint bargaining of these divisions developed over twenty years (Olson, 4694-4700, 4706, 4716-19; Ratner, 3710, 3725-33, 3738). Proposals are submitted by each separate division; each classification has at least one representative at the bargaining table; and there are local negotiations for specific issues at some hospitals after the master negotiations (Ratner, 3739, 3742, 3757-59; Olson, 4702; Muehlenkamp, 4782). At Michael Reese Hospital, the service and maintenance unit and the business office clerical unit bargain jointly but have separate committees, contracts, and stewards (WS Gray).

There is no evidence of a trend toward coordinated bargaining (Shea, 5217-18). In New York City, there has been some movement away from the citywide approach of Local 1199; there is pressure to go back to each hospital

after the master agreement to get separate provisions on local issues (Ratner, 3739).

Although some industry commentators now request broad-based units, there are a number of instances in the record in which employers sought, for example, to have RNs in a broad unit with other professionals, and then raised the question of effectiveness of bargaining representation, or appropriateness of unit. See section V, Registered Nurses, *infra*. To the extent that employees represented in different units may wish a number of years later to re-group as a single larger entity for purposes of conducting negotiations, nothing in the rule would interfere.

In sum, the record fails to demonstrate that finding a limited number of occupationally-homogeneous units to be appropriate would inhibit functional integration on the job, increase strikes, jurisdictional disputes, or wage whipsawing, or substantially increase costs to industry or to workers. Rather, we believe that finding only two broad units appropriate would unduly hamper organizing and effective bargaining, and would not carry out Congress' intent in the health care industry.

V. Registered Nurses

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that RNs constituted a separate appropriate bargaining unit in acute care hospitals having more than 100 beds. 52 FR 25146. Among the reasons assigned were that RNs:

- (a) Work around the clock, 7 days a week;
- (b) Have constant responsibility for direct patient care;
- (c) Are subject to common supervision by other nurses;
- (d) Share similar education, training, experience and licensing not shared by other employees;
- (e) Have the most contact with other RNs; and
- (f) Have a lengthy history of separate organization and bargaining.

Much of the evidence taken at the rulemaking hearings concerned the RN classification. As discussed in more detail *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, in other respects, after carefully considering the evidence amassed, we have determined that RNs appropriately constitute a separate bargaining unit.

B. The Record Supports a Finding That RNs Constitute a Separate Appropriate Unit

1. *Work schedules.* There was some evidence of selected other professionals who, at certain hospitals, might be scheduled to work evening and nighttime shifts (Comment 72, McCarthy; Comment 82, Humana). However, the evidence was overwhelming that only RNs have a professional responsibility which requires them as a group to be on duty 24 hours a day, 7 days a week (Chow, 3107-08; Ballard, 55; Schauer, 3155; Ratner, 3735; Graham,

4841-42). They are the only professionals regularly required to work overtime, including as much as two 8- or 12-hour shifts (Bachus, Chi I 144; Wilson, 5074, 5091).

2. *Responsibilities.* Each professional classification obviously possesses its own singular job function and responsibility. However, whereas other professionals specialize, and have intermittent contact with patients, nurses are unique in that their profession demands continuous interaction with patients (Dumpel, 3277-78; Chow, 3108; Ballard, 55, 57-58, WS at 7; Foley, 446). Nursing practice involves the nursing process by which nurses assess patients, as reflected in the nursing practice acts (Comment 240, ANA, Kalisch; WS Foley at 4; WS Ballard at 9-10). RNs continually monitor all patients to be sure that physicians' orders are being carried out and that treatment procedures are not proving harmful (Ballard, 55-56; Bullough, 4627-30). RNs must be alert for errors made by other professionals; for example, if another professional, e.g. a pharmacist, dispenses medication in an improper dosage, the overall responsibility rests with the RN who, if she administers it, is also responsible (Reier-son, 3606-07; Sackman, 3586). The RNs' special responsibility is based on a cluster of knowledge which they possess, as opposed to a single skill (Bullough, 4629-30). One 1982 study by Posavac showed that the "perception of nursing care is the single most crucial aspect in the overall rating of hospitals by patients" (Fine, 3143).

3. *Supervision.* All acute care facilities have an organized department of nursing, and that department is supervised by a nurse (Ballard, 52-53). For this reason, the vast majority of nurses in hospitals are ultimately responsible to the director of nursing (Ballard, 67; Lipari,

3703; Gilmore, 4909-10; Comment 293(b), Jones: 3 RNs out of 99 not in nursing department; Comment 293(g), Soltis: 11 out of 200 not in nursing department). The evidence did indicate that in some instances nurses work in departments other than nursing and are subject to supervision by these other departments, such as ambulatory services, discharge planning, home health care, and anesthesiology (Graybill, 4149; Comment 139, S. Baltimore Hospital). However, even in the few instances where a nurse might be hired into another department and report to someone other than the director of nursing, the director of nursing is still responsible for the delivery of nursing care (Ballard, 67-68; Indelicato, 3680).

Product line management is a system of organization by type of service and in response to the DRG method of payment (Dalstrom, 332; Houston, 4024; Kennedy, 5552). It is argued that, with this type of structure, nurses have more in common with those in their product line than with other RNs with whom they have little contact (Dalstrom, 336-339). Ordinarily however, it results in some RNs' being responsible to a functional manager of a project and to nursing heads for clinical issues (Comment 293(i), Feldsine, at 2-3). Product line management is a financial tool; it does not result in changes in interaction among hospital workers (Kennedy, WS at 6-7). As noted *supra*, nurses overwhelmingly continue to report to nurses (Dalstrom, 335: Only 10% of RNs not members of nursing division, but no showing that not supervised by an RN).

4. *Wages.* The labor market for nurses is distinct from that for other professionals (Gonzalez, 4356). Thus, nurse salaries are low, even within the framework of

hospital compensation (Corbett, 3332, 3335). There is no pressure from outside the hospital industry forcing up wages, as for example is the case with pharmacists (ANA Br. 97). Moreover, the overwhelming percentage of nurses are women, and there is evidence that this has contributed to the separateness of the RN wage structure and the distinctiveness of their concerns (Muehlenkamp, 4779; Saporta, 5114-15). When nurses and employers bargain about wages, they look to wages of RNs at other hospitals, not at wages of other professionals (Patek, Chi I 78-79; Absalom, 3316-18). Finally, RN career ladders are very short in terms of pay, quickly levelling out after relatively brief experience (Rosen, 4671). Hospitals recognize the separate RN market by having nurse recruiters; no similar position exists for other professionals (Ballard, 65; Reiersen, 3606-09).

Nurses traditionally conduct wage negotiations from these unique disadvantages despite the demand for their services (ANA Br. 99). In fact an employer may insist on a separate wage scale for RNs in an all-professional unit (Comment 51, Castrop: employer reopened wall-to-wall contract at O'Brien to increase RN wages only).

5. *Wage whipsawing or leapfrogging.* The record evidence based on actual experience shows that wage leapfrogging has not occurred in the hospital industry (Ratner, Local 1199, 3744; Friedman, Local 1199, 5041, 5045; Absalom, CNA, 3316-3317; Muehlenkamp, NUHHCE, 4775; Twomey, WS at 6, Hosp and Prof Allied Employees of NJ; Schmidt, Oregon Federation of Nurses, AFT, WS at 4; Shea, SEIU, WS at 13-14). The one example offered by the industry as evidence of leapfrogging (involving RNs) occurred 20 years ago in California and

concerned the adjustment of wages for RNs who had been underpaid for a long period of time as compared to other hospital employees (as found by a factfinding panel appointed by the governor). Even this adjustment did not result in any disruption of patient care. Moreover, other professionals did not obtain higher wages or benefits thereafter as a result of the RN unit adjustment (WS Absalom, at 7-8; 3286-87).

The fact that RNs are in a different labor market mitigates against leapfrogging (Shepard, 4959-60). Special considerations such as the nursing shortage, recruitment, and retention are not concerns of other professions and have not been carried over into other units (Absalom, 3316-3318). In addition, there are certain limitations or rigidities in the financing system which preclude the pass-through of spiraling wage increases. A significant limitation is found in the Medicare and Medicaid reimbursement rates. These rates play a prominent role in the economics of hospitals, and are set in a regional area in accordance with the general wage pattern set by the most influential local union and its employers. Thus, there is little incentive for unions to engage in whipsaw strikes and efforts to leapfrog the pattern of wage increases. (Friedman, 5044-45.) Finally, it appears that concern about the potential for leapfrogging could be ameliorated by uniform contract expiration dates. However, the evidence shows that hospitals have declined to accept union proposals to this end. (Henry, 3074-76; Absalom, 3318-19; Sackman, 3586; Willman, 4480-82; Clark, 4685.)

6. *Education, training, experience and licensing.* All professions require specialized education and training

(AHA Br. 15; *Mixon*, Chi II 274), and are subject to prescribed standards of practice (California Health And Safety Code Sec., cited in AHA Br. 15; Comment 248, Cedars-Sinai Medical Center). However, in addition, nurses must pass state licensing exams, which are uniform throughout the country, after graduating from an accredited nursing school. A candidate who passes the exam is competent to practice throughout the country. (Reierson, 3597.) Nurses are required to follow, *inter alia*, state nurse practice acts, and no other health care worker may function as a nurse under nurse practice acts (Ballard, 56, 57).

RNs' licensing requirements may actually conflict with the requirements and practices of other professions. For example, as previously indicated, RNs fill out incident reports on mistakes in medication dosages made by other workers (Reierson, 3603; Sackman, 3586). This type of responsibility may result in antagonism between the RNs and other professionals which might impede collective bargaining by the professionals as a group.

Several states mandate continuing education for nurse relicensure. Only social workers and pharmacists are subject to such requirements in more states than RNs. (ANA Br. 48; Ballard, 54; Lumpkin, 87.)

7. *Interaction.* RNs work in close and continuous contact with one another within the same hospital (WS Foley; Owley, 4377-78). Moreover, sometimes RNs at different hospitals have more contact with one another than with the other professionals in their own institutions (Owley, 4378; Schauer, 3156-58). With respect to RNs' interaction with non-nurse professionals, while there is

some contact, it is not regular and recurring. There are a variety of factors which help to explain why interaction among RNs and non-nurse professionals is limited. For one thing, while there was testimony that there is a crossover of duties between RNs and other professionals (Thompson, Chi II 55-58), there was also testimony that licensing and other regulations clearly prevent RNs from doing much of the work of other professionals and other professionals from doing RN work (Lipari, 3702; WS Dumpel & 3279). Moreover, non-nurse professionals generally are located away from patient units where RNs are located. For example, in Local 1199-organized hospitals, most pharmacists are located in self-contained units, usually in the hospitals' basements. (Crisafulli, 3712-14.) Moreover, RNs typically have different working hours (Indelicato, 3681; Ahmed, 3707). As noted by the ANA, the contact RNs may have with respiratory therapists is not material since respiratory therapists consistently have been found to be non-professionals. See for example *Samaritan Health Services*, 238 NLRB 629, 638 (1978); *Barnert Memorial Hospital Center*, 217 NLRB 775, 779 (1975).

The point is made that RNs in many cases have more frequent contact with other professions than those other professions that the Board proposes to place together have among themselves (AHA Br. 20-21, citing *Long Island Hospital*, 256 NLRB 202 (1981), and other Board cases). However, this point militates more against grouping of the different professionals than it does toward grouping the RNs with other professionals.

8. *The team concept.* Much evidence was offered during the proceeding concerning the team concept. See also section IV(B)(1), *supra*. After carefully considering this

evidence and the parties' arguments in connection therewith, we conclude that the fact that some hospitals utilize the team concept does not detract from the separate appropriateness of RN units.

There are two types of teams found in hospitals. The first is the nursing team which consists of RNs, LPNs, and aides. This type of team is found throughout the industry. However, as this team contains only nurses and non-professionals, and the Act provides that professionals are entitled to a separate unit if they choose, the nursing team is not relevant to the issue presented.

The second type is the multidisciplinary team which contains various classifications of professionals and non-professionals and has been utilized in the health care industry since the early 1900's. Employers unsuccessfully relied on the existence of teams in an attempt to defeat the 1974 Amendments. (ANA Br. 126, citing Ohio Hospital Association testimony.) The team concept remains non-persuasive for several reasons. First, the evidence at the hearing established that many hospitals do not even use the team concept (e.g., McCullough 4819; Gilmore 4910). Moreover, except for some specialized hospitals, e.g., children's hospitals (Sokatch 4194, 4199; Gallagher, 3539, 3543-46), those hospitals with teams often have no more than six or seven teams (Thompson, Chi II 14-15; Mixon, Chi II 294-96; Graybill 4172-86; Comment 283, Leavenworth), with two to eight members on a team (Thompson, Chi II 72; Mixon, Chi II 277; Gallagher, 3543-45). Thus, within the limited number of hospitals that use teams, only a minority of nurses and other professionals participate on the teams (Bachus, Chi I 129-132, most teams are on the management level).

Although one comment stated generally that the downsizing of staff has led to more teamwork (Comment 263, Huntsville Mem. Hosp), this was not supported by other specific examples.

While members of teams may have daily interaction and weekly formal meetings (Comment 78, Greater Cincinnati; Comment 288, Graybill, Children's Medical Center, Akron), there was also testimony that the interaction of RNs and other professionals is limited in certain ways. For example, team members only interact with the few other members on their teams. Additionally, other duties of RNs may prevent or limit their actual participation in an assigned team program (Schmidt, 3627, 3635; Bachus, Chi I 129-130; Reiersen, 3609-10). More importantly, the fact that the RNs may interact and work with other professionals on teams does not alter the separateness of their identity. The team approach is a process to ensure that the elements of patient care are organized. The evidence was uncontradicted that it does not alter each licensed professional's responsibility for his or her individual scope of practice. (Ballard, 56; Twomey, 131; Wilson, 5095; Bachus, Chi I 129-130.) Nor does participation by some RNs in team care affect wages, hours, benefits, training, skills, or functions of RNs on or off the teams (Graybill, 4174-75; Houston, 4044-45).

Conversely, separate RN units were not shown to have interfered with team care (Gallagher, City of Hope, 3540; Bullough, 4651 and 4653; Houston, Sacred Heart, 4031, 4038, 4048). The industry offered only unsubstantiated speculation that team care would be adversely affected; e.g., one witness testified that the amount of interplay, the exchange that goes on minute-to-minute in

critical situations, could be damaged significantly (4185-86). However, at City of Hope, a specialized cancer hospital with a large number of teams and a separate RN unit, the teams remained able to deliver a very high level and quality of care. (Gallagher, 3540 & 3543; Bullough, 4653. See also Thompson, Chi II 9, 86-87: no evidence that separate RN representation at her Ohio hospital has made nurses less able to function as a team.)

9. *Cross-training and interchange.* Because of licensure limitations, cross-training does not take place between RNs and other employees (Lipari, 3702; Dumpel, WS & 3279). Hospital codes also preclude replacement of RNs by other professionals (Rosen, 4666). It logically follows that the extent of interchange between RNs and other non-nursing professionals is limited not only because of RN licensing limitations but also because of the licensing requirements of other professional employees. There was testimony that RNs will perform functions of other "professionals" when the latter are not available, e.g., moving patients instead of physical therapists, or doing respiratory therapist work at night and on weekends (Comment 78, Greater Cincinnati; Comment 198, Marshalltown Medical Center). With respect to the first example, the performance of non-professional tasks such as transferring patients to wheelchairs is not relevant to interchange between professionals. Similarly, respiratory therapists consistently have been held by the Board to be non-professionals. Finally, other examples of interchange, such as medical technologists' watching the heart monitor while a nurse is on break (Houston, 4041-42, 4026-27), appear to be minimal. It was also stated

that both pharmacists and RNs dispense drugs and medications; however, pharmacists typically formulate medications and advise on proper medications while RNs administer them (Thompson, Chi II 55-58).

10. *History of representation and collective bargaining.* The ANA, representing RNs, stated that the RNs' desire to be organized to protect their interests as well as their patients' interests began nearly 100 years ago, and persisted through the onset of collective bargaining and the original Taft-Hartley exclusion of employees of non-profit hospitals from federal labor law (ANA p. 74; see Comment 240, attachment, Kalisch, Twelve Key Steps in the Process of Professionalization of American Nursing, 1854-1987; Comment 293, ANA, Flanagan). AHA contends that separate bargaining by RNs does not reflect a freely established pattern because, prior to the 1974 amendments, it was to some degree based upon considerations of the then-current law in each state and because collective bargaining primarily existed only in a few isolated parts of the country and thus could not be deemed representative. Moreover, the AHA contends, subsequent to the 1974 amendments such bargaining was established pursuant to the direction of the Board.

Regardless of what might first have provided the impetus, RNs have for many years exhibited a strong desire for separate representation. Even during the period following *St. Francis II*, RNs consistently sought separate RN units but were forced to organize into units with other professionals or face lengthy, costly, and fruitless litigation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson 5069). Although forced to include other professionals, the organizing drives were

strikingly similar to prior nurses-only campaigns. Testimony indicates that the campaigns were led by nurses, issues prompting organization were nurses' issues, and the bargaining was performed by nurses, often with no participation by other hospital professionals. (Gonzalez 4356; Splain, 5293; Lumpkin, 99-100; Patek, Chi I 54-55; Chow, 3108; McCullough, 4811; Gilmore, 4894; Shepard, 4927.) Moreover, comments from a number of hospitals indicated they have not had problems bargaining with separate RN units (Comment 79, Baptist Hospital; Comment 105, Mass. Hosp. Assn: 2 examples; Comment 121, Central Michigan).

The AHA makes the point that the more recent history of collective bargaining shows that all-professional units nonetheless are viable, and the record offers some support for this position. Thus, even some RN-only unit proponents have testified that the interests of all professional groups have been adequately represented in bargaining for an all professional unit.²¹ (AHA Br. 24.) However, while bargaining could undoubtedly proceed in any one of a number of configurations, this does not necessarily answer the question whether a separate unit of RNs might not also be appropriate; or better reflect the wishes, needs and interests of RNs, other professionals, and perhaps even health care providers themselves.

²¹ That other professionals have not filed unfair labor practice charges or grievances against unions where nurses predominate, charging breach of duty of fair representation, does not mean other professionals are satisfied with representation. A breach of the duty of fair representation is found only where conduct is arbitrary, discriminatory or in bad faith. *Vaca v. Sipes*, 386 U.S. 171, 190 (1967).

The testimony shows that not only have the RNs desired separate representation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson, 5069), but other professionals do not appear to react favorably to their inclusion with RNs. As noted *supra*, the other professionals often do not participate in the organizing campaigns and are hostile to being included in bargaining units with RNs. As an example, when Capitol Hill Hospital demanded inclusion of other professionals, the other professionals complained, became hostile, and some even requested separation (Gonzalez, 4351-53). In Langlade Memorial Hospital, Wisconsin, other professionals forced into a unit with RNs tried to decertify the union but were outvoted by the RNs (Owley, 4376).

The main concern of the non-nursing professionals is of being overwhelmed by the large number of nurses and not having their concerns given priority. RNs are the largest professional group in any hospital. In fact, RNs constitute approximately 23% of the hospital workforce (WS Schoen, Table 1, citing data from AHA publication and BLS Hospital Wage Survey.) They may outnumber other professionals by a ratio of 4 to 1 or more. (AFL Br. 92; Twomey, 123-125, 128-129; Gafni, 133-135; Thompson, Chi II 58.) The non-nurse professionals are also concerned that RNs could ignore their interests when they conflict with RNs' (Comment 134, American Physical Therapists Assn). A number of non-nursing professionals who testified at the hearings confirmed the lack of interest which RNs exhibited toward their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. See section VII, Other

Professionals, *infra*. Evidence showed that even when made part of a unit which wins an election, other professionals sometimes do not participate in negotiations or come to union meetings (Schauer, 3154; Wilson, 5070; Patek, Chi I 54, 55-67 and WS 6-7). Issues discussed during bargaining tend to be those of interest to nurses (Wilson, 5073). Moreover, most grievances at one hospital were from nurses on nurse issues (Bachus, Chi I 122). There is a concern that if forced into units with RNs and RNs do not want representation, other professionals would not have enough votes to obtain representation (Owley 4376-77; Ahmed, 3707-08).

The AHA argues that the size of the RNs' group relative to other professionals should not be a consideration in determining whether to have an all-inclusive unit, and that this is a clear departure from the Board's general unit determination analysis in which the Board routinely has included small ancillary groups in units with one or more large classifications that constitute the bulk of the unit. We acknowledge that units frequently are an amalgam of other special interest categories. See, e.g., *Airco*, 273 NLRB 348 (1984). Nonetheless, the Board routinely also finds appropriate separate groups whose interests have been shown to be sufficiently distinctive. See, e.g., *Pacesetter Corp.*, 241 NLRB 1150 (1979) (separate unit of over-the-road drivers found appropriate); *Newburgh Mfg. Co.*, 151 NLRB 762 (1965) (separate unit of garment cutters found appropriate.)

Some employers argued that the real reason unions want separate RN units is that their constitution and by-laws do not permit them to organize other professionals (Comment 306, Herrin). However there was testimony

that some nurses' associations have amended their by-laws to allow organization and representation of other professionals (Gonzalez, 4362; Sackman, 3578). In addition, there was testimony that some employers' true concern with allowing separate RN units is not unit fragmentation but defeating unions. Several witnesses testified that their employer demanded inclusion of other professionals with nurses when nurses wanted separate representation, but then told the RNs they should not include other professionals who did not have their interests. These same employers told the other professionals that they should vote against the "nurses'" union because they would be a minority and nurses could not adequately represent them, thus contradicting the argument of many employers in this proceeding. (Gonzalez, Capitol Hill Hospital, 4351-53; Gilmore, 4896-97; Absalom, 3315; Saporta, 5134; Sackman, 3580-84; WS Splain at 18-19; Wilson, 5096-97.) Employers have also requested the inclusion of lab technicians with RNs, then challenged their inclusion (Wilson, 5087-89).

In several instances, employers who earlier had insisted on the inclusion of all professionals later opposed bargaining with the RNs and other professionals in a single unit when the nurses' union was selected as bargaining representative of an all-professional unit. For example, after the D.C. Nurses Association won an election in a broader unit demanded by the employer, the employer at negotiations proposed removal of non-RNs from the agreement, saying its earlier position had been based on "tactics." (Gonzalez, Capitol Hill Hospital, 4355; see also Lumpkin, Shands Hospital, 95: hospital asked to amend unit to separate RNs from non-RNs; because of

problems with recruiting and retaining RNs, the employer needed to set innovative scheduling, overtime pay for shifts, premium pay.)

11. *Collective bargaining interests.* There are a number of issues of unique concern to nurses in collective bargaining (See Comment 240(b), submission of David Martin, RN, ANA senior staff specialist for labor relations, affidavit analyzing 190 RN-only unit contracts representing nearly every such contract negotiated in 1986). While there may be examples of how special concerns of the RNs have been addressed in all-professional units, this does not necessarily demonstrate that RNs and other professionals have large numbers of common interests. Nurses can emphasize these issues in bargaining regardless of the concerns of non-RN professionals because RNs would constitute 80% or more in a typical unit (WS Shea at 22), and often 100% of those willing to participate in bargaining (Gonzalez, 4355-4356).

Moreover, that unions are capable of addressing special concerns of the RNs in all-professional units does not negate the fact that many of these issues are unique to RNs and that separate representation would frequently provide a more efficacious and just means for responding to their concerns. For example, RNs alone have recurring concerns with respect to floating, i.e. being temporarily transferred from one unit to another to cover understaffed units (Schauer, 3115). RNs have bargained for mandatory orientation both in their own unit and before floating to other units (Schauer, 3115; Comment 240(b), Martin affid.: orientation provision found in 83 of 1986 contracts). Some organizations representing nurses have created "Assignment Despite Objection" forms to be used

when nurses are asked to work in a unit or perform a function for which they feel unprepared (Graham, 4827; Shepard, 4929-31). Floating and orientation generally do not concern other hospital professionals since they typically are not required to float to areas where they may be unqualified (Saporta, 5114; Indelicato, 3681). Moreover, other hospital professions are not as concerned with staffing in general because they do not have constant patient care responsibilities like the RNs and because they are not in critically short supply (Gonzalez, 4364; at Capitol Hill, staffing was a major concern for RNs, not at all for other professionals).

The evidence shows that scheduling issues are of much greater concern to RNs than to other non-nursing professionals. RNs are virtually alone in their concerns with respect to mandatory overtime and double or rotating shifts, or evening, night and weekend shifts, all of which are said to increase the likelihood of nurse error. (Bachus, Chi I 144; Lipari, 3697; Korn 4860-61; Chow 3111, Ballard, 62, 75.) There were only isolated examples of non-nurse professionals working late shifts or weekends. Many other professionals, like social workers, work primarily day shifts during the weekdays. (Roth, 3151: no pharmacist, social worker or physical therapist at night, skeleton crew for respiratory therapy; WS Foley at 6-9: social work, physical therapy, doctors, offices are all closed by 6 p.m., some evenings only RNs provide primary care.)

Collective-bargaining agreements have addressed these issues *l.*, e.g., attempting to limit mandatory overtime, rotating shifts, etc. (Comment 240(b), Martin affidavit; Chow 3110-11.) Collective bargaining agreements

covering other professionals do not usually include such provisions (Friedman, 5055; Local 1199 contracts for medical technologists do not prohibit mandatory overtime).

Hospitals have difficulties attracting nurses to work the less desirable evening and night shifts. Ninety-eight percent of contracts in the ANA study provided higher wages on evening and night shifts; 57% offer some form of alternative scheduling designed to attract RNs. (Comment 240(b), Martin affidavit.) Other professionals generally view issue of premium pay and alternative scheduling as less important or irrelevant. This in part is due to the fact that non-nursing professionals usually do not work night shifts and many do not work evening shifts (Patek, Chi I 55: non-RN professionals had grave concerns about bargaining over premium pay for fear that this would mean that they would be required to work shifts they had not worked before. See also WS Lumpkin, *supra* at 8: re: innovative scheduling for RNs; Gilmore, 4907.)

12. *Education.* Nearly every surveyed contract has provisions for continuing education which is mandated in 15 states (Comment 240(b), Martin affidavit). Continuing education typically presents different issues for nurses, who work around-the-clock schedules and have difficulty attending the courses, which are often given evenings, nights, or weekends. Thus, other professionals typically bargain about continuing education by seeking more money; RNs seek time off to attend as well as tuition. (Lumpkin, 86-88; Foley, 449-450.) This in itself would not justify a separate unit as such concerns could, of course, be accommodated in larger-unit bargaining; however, they are but one of a congeries of concerns and

special problems that make nurses a substantial, unique group.

13. *RN bargaining units and strikes.* There is testimony that there have been many strikes by nurses (King, Chi II 41, 46, 28; Whelan, Chi II 59-61, 85; Comment 304: one-third of 20 strikes at Kaiser since 1974 amendments are in RN-only units), and that some of these strikes have lasted for a long time (e.g., Ashtabula Hospital, Ohio, 572 day strike: King, Chi II 28, 59-61). However, according to available FMCS data, only 3.3% of all health care contract negotiations, including nurse bargaining, resulted in strikes. The strike percentage in any given year never exceeded 5.1% and fell below 2% in several years. Moreover, during the 1984-1987 period, strikes in the health care industry occurred far less often than in other industries, 1.5% v. 2.4%. (WS Schoen at 28; AFL-CIO Exh. 6.)

There was testimony that RN strikes are particularly disruptive because RNs constitute the largest group of hospital employees. For example, there was a strike of 6,000 nurses in Minneapolis-St. Paul in 1984 over job security (Patek, MNA, Chi I 51, 63). But there was also testimony that where strikes occurred, the hospitals continued operation (Whelan, Chi II 59-60; Viat, 3471). Moreover, we must also be mindful that in an all-professional unit, RNs, because of their predominance, could generally obtain an affirmative strike vote even if all the other professionals were opposed. Because such a strike would involve all professionals in the hospital, greater disruption of hospital services would result than with a separate RN unit. (ANA Comments 173.) Finally, for 18 years ANA had a no-strike policy (Shepard, 4931-32; Comment

293(k), Flanagan, *Collective Bargaining and the Nursing Profession* at 14-15), and CNA has adopted a standing policy that in the event of an impasse in arbitration, it will offer binding arbitration before resorting to strike action (Absalom, WS at 8-9, 12-13, 15-16 & 3286-98: 1974 strike resolved by FMCS; 1978 shift rotation disagreement resolved by advisory arbitration; 1980 disagreement on nursing shortage resolved by mediation-arbitration).

The AHA argues that the history of the RN-only unit bargaining does not support a conclusion that potential work disruptions are not increased by creation of multiple professional bargaining units, since the overwhelming majority of facilities where RN units exist have no other professional units (AHA Br. 24). However, because in all likelihood the latter phenomenon would continue to exist, this argument is not entitled to great weight.

Some commentators argued that multi-professional units may lead to sympathy strikes (Bennett, 3045; Comment 13, Corkin). However, most no-strike clauses in hospital contracts forbid sympathy work stoppages, and there was evidence it is common for RNs to cross picket lines set up by non-nurse health care workers (Sackman, 3585; Lipari, 3696; Korn, 4889; Roth, 3152-53). If sympathy strikes were a problem, it appears that they could be significantly reduced by mandating common expiration dates for all hospital contracts, a proposition which, the evidence showed, hospitals frequently or even universally have rejected (Absalom, 3318-19: Affiliated Hospitals refused to allow new expiration date to coincide with expiration of other contracts; Clark, 4683-85: no common

expiration dates for initial contracts; Abelow, 249-50; no push from any parties to coincide RN contract expiration with master contract of League of Voluntary Hospitals; Lipari, 3697: employer opposes common expiration dates).

14. *Jurisdictional disputes.* The record does not reveal a single jurisdictional dispute between unions of professional employees (Fine, 3156-3158). Witnesses who asserted that such jurisdictional disputes would arise did not substantiate their claims (Dalstrom, 339; O'Connell, 440; Dauner, 3199; Emanuel, 3503-04; WS Cammarata at 7). In fact, the most typical job duty issues involving jurisdictional lines are between RNs and nonprofessionals, i.e., LPNs and nurses' aides (WS Shea at 14). These types of issues would arise even if the RNs were placed in an all-professional unit.

As was the case with regard to strikes, the AHA argues that an assessment of the impact of multiple professional units on jurisdictional disputes can only exist where there are two or more units represented by labor organizations in a facility, and there are very few such instances (AHA Br. 24). For this same reason, we believe the argument that there is a potential for jurisdictional disputes among professionals where a separate RN unit is given, is speculative. To the extent the record deals with this matter, it shows that any issues regarding the possible overlapping duties of professionals have in the past been fought out in the public arena. For example, attempts by other groups to perform some of the nurses' duties under their scope of practice in California were dealt with by the legislature. (Dumpel, 3278-79.) In any event, as noted *supra*, (see subsection (B)(9) on cross-

training and interchange), interchange of duties between professionals appears minimal.

15. *Nursing shortage.* It is common knowledge, and the record substantiated, that currently there is an unprecedented and severe nursing shortage (Absalom, 3295; Shea, 5235; WS Schoen at 16, citing ANA Report on Hospital Nursing Supply). Some hospitals have delegated some traditional RN functions, not reserved to RNs by law, to employees with no RN training. Additionally, hospitals currently have more seriously ill patients (higher acuity) than historically reported. Less qualified nurses, and fewer nurses, will be forced to attend to more seriously ill patients, leading to a lower level of care and more stress for the remaining RNs who may then opt out of nursing. (ANA Br. 101, and articles cited therein.)

Nurses testified that they view collective bargaining, in their own unit, as the vehicle for improvement in their working conditions and for allowing them a voice in patient care (Ballard, 72; Lumpkin, 85-86). Additionally, hospitals are trying innovative proposals for nurses: opening contracts for them alone, raising wages, setting weekend differentials. Some think that if other professionals are included in units with RNs, problems could arise if such changes are also not implemented for non-nursing professionals. (Wilson, 5071; Saporta, 5116.)

It has been argued that the Board should not give special consideration to a group in temporary crisis or other groups will also make demands for separate units (Comment 65, Milford Hospital). However, while the evidence establishes that the situation is a serious one and appears to be growing more serious with time (ANA Br.

100-101, and articles cited therein), we view this as only one valid factor in determining the appropriateness of a unit limited to RNs. The concern that this will lead other professionals to follow suit is speculative, and insufficient reason to deny RNs, who have already established their unique concerns and a highly separate identity, a separate bargaining unit.

16. *Proliferation of units.* As has been documented elsewhere, the evidence in the record does not support the assumption that the recognition of RN-only units will lead to a demand by other professional groups to organize as separate units. In fact, as previously indicated, the AHA acknowledges in its brief that in the overwhelming majority of facilities where RN units exist, other professionals have not been represented in separate units. (AHA Br. at 24.) SEIU health care organizing director Splain concluded that 10 years of statistics show relatively little organizing in residual hospital units. There are 16 hospitals in Ohio that have a separate RN unit, and only one unit in which professionals other than RNs are represented separately. (King, Chi II 38-39; Shepard 4927.) Health care workers organize no more frequently in facilities where some workers engage in collective bargaining than they do in facilities where no bargaining units have been represented (WS Splain at 14-17). One witness testified that a typical hospital has an RN unit, an LPN unit or technical unit, a service and maintenance unit, and sometimes an operating engineers unit (WS Patek at 4).

C. Conclusion

We have carefully considered the evidence in the hearings as to how a separate RN unit, or, in the

alternative, an all-professional unit including RNs, might fare, based on the realities of hospital operations, organizing, and collective bargaining. We conclude based on this evidence and the arguments advanced that a separate RN unit is appropriate for collective bargaining purposes.²²

For many years, RNs, who constitute a significant portion of the health care workforce, have demonstrated their commitment both to their careers in the health care industry as well as their patients' well-being. During the time period following *St. Francis II*, it appears that RNs consistently desired separate RN units but were compelled to organize into all-professional units in order to avoid prolonged litigation. However, even when the RNs were forced to include other professionals in their units,

²² In making our decision on this issue, we have considered *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), a fairly recent case in which we held in an adjudicatory proceeding that a separate RN unit was inappropriate. In so doing we found, *inter alia*, that all of the employer's professional employees "share common personnel policies and procedures and fringe benefits and have sufficient contacts and interaction to support the finding that the smallest appropriate bargaining unit is one consisting of all of the Employer's professional employees." *Id.*, slip op. at 13. Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations, and of the actual and potential ramifications of each type of unit. For the reasons stated in this section, were we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

the organizing drives were quite similar to prior nurses-only campaigns.

Moreover, it is apparent from testimony taken at the hearings that non-nursing professionals did not wish to be included in a unit with RNs. If we ignore the perspective of the smaller, non-nursing professionals group, i.e., the animosity expressed toward their inclusion with RNs as well as their concern that their "voice" will not be heard, then we are disregarding, at least in part, one of our major objectives. As previously indicated, the Board seeks to avoid finding too large a unit appropriate, as this may result in "too diversified a constituency which may generate conflicts of interest and dissatisfaction among fringe groups, making it difficult for the union to represent * * * ." See section III, Standard To Be Applied, *supra*. This latter point appears to be a concern of nursing and non-nursing professionals alike, and is one reason we have decided to permit RNs to seek bargaining rights apart from other health care professionals.

There was also testimony that would lead us to believe that some hospital employers' true concern with prohibition of separate RN units was not possible fragmentation but rather defeating organization. This was demonstrated by evidence of, *inter alia*, employer opposition to bargaining with the RNs and other professionals in one unit when an all-professional unit was finally certified, despite these same employers' earlier efforts to require that all professionals be included.

The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit

is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern. These factors and others discussed *supra* support a finding that collective bargaining by RNs as a separate unit should be permitted.

The industry has contended that adverse consequences would follow having separate RN units, such as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities.

Finally, we are mindful of the growing problem involving the nursing shortage. While separate representation for the RNs does not provide the complete solution to this problem, we believe that it is an important step toward making the nursing profession a more attractive employment opportunity as the separate concerns of RNs are addressed more directly in a separate RN unit.

VI. Physicians

In our Notice of Proposed Rulemaking, we provided for separate units of physicians in acute care hospitals having more than 100 beds. Although we did not anticipate the formation of many such units, we stated we would permit them because of physicians' separate education, training, and skills, and particularly because of physicians' unique position as the ultimate supervisors of patient care.

As discussed *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, as with RNs, see section V, *supra*, the evidence produced during this proceeding supported the proposed separate unit of physicians.

Doctors have considerably more training than other professionals, i.e., four years of medical school plus two to six years of post-graduate residence training, working as student residents in hospitals under the tutelage of licensed physicians (WS Cornfield).

Doctors have the singular responsibility of directing all other patient care employees; the JCAH charges doctors with overall responsibility for the quality of professional services (Robinson, 3650-51; WS Todd at 4-5, citing 1987 Accreditation Manual). Malpractice claims are filed against doctors because they are responsible for medical treatment (Robinson, 3652). The AHA contends that all professionals are held responsible for malpractice (AHA Br. 30); while we do not doubt the truth of this assertion in some circumstances, the AHA offered no details.

It is common knowledge that doctors earn substantially more than other professionals. They are frequently salaried, entering into individual employment contracts with hospitals rather than having an overall wage scale applied to them. (Comment 94, Somers; Robinson, 3652; NYS Federation of Physicians' and Dentists' position paper Exh. D.)

Supervision of doctors is limited and is generally done by other doctors (Robinson, 3651; Comment 293, Feldsine). While we recognize that other professionals are also commonly supervised by their peers (Comment 71,

Kowalski, St. Mary's Hospital), as indicated doctors are ultimately responsible for the care given patients.

Doctors, of course, work with other employees, particularly on teams, or committees (Comment 137, McDonough Hospital; Mixon, Chi II 291; Comment 248, appending statement from Spitzer of Cedars-Sinai). However, we are persuaded by the evidence that the team approach does not change the duties of doctors, which are limited by law. Other employees are not permitted to do work within doctors' scope of practice. (Todd, 4348; Comment 269, Todd, AMA.)

Aside from the other factors noted, doctors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions (Robinson, 3655). They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime, etc. (NYS Federation of Physicians' and Dentists' position paper, Exhs. B, D, E, and F), and are outnumbered by nurses at a ratio of at least 15:1 (Todd, 4324, 4328), and perhaps 20:1 (AHA Br. 28). We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed (Todd, 4324). Florida, after 10 years, removed doctors from an all-professional unit in state facilities because of money considerations (Lumpkin, 100, 111-12). In one wall-to-wall unit including doctors, the hospital wanted raises just for doctors because of recruitment problems; the union opposed this because it would give raises just to one group in the unit (Robinson, 3654-55). A number of employers similarly expressed concerns about putting physicians in units of other professionals (Comment 94,

Somers, attorney to many health care facilities: Comment 304, Kaiser Permanente; Comment 1, Lancaster Fairfield Community Hosp.; Comment 17, Middletown Regional Hosp.; Comment 48, St. Vincent's Medical Center, Bridgeport; Comment 141, Ayres). A wall-to-wall unit at O'Bleness Hospital did not include doctors (AHA Exh. 8D).

While the number of doctors employed in hospitals is small, and the percentage of employed doctors compared to other employees remains about the same, the actual number of employed doctors is increasing (Todd, 4335), and there is some evidence that doctors are organizing at increasing rates (AFL Exh. 4).

We are persuaded that the evidence weighs in favor of a separate unit for physicians, where sought. Thus, to include them with RNs and other professionals seems likely to lead to divisiveness and quite possibly to conflicts of interest. We have found no evidence that to grant doctors a separate unit would lead to repetitious bargaining, frequent strikes, or jurisdictional disputes. We believe the proper balance is struck in favor of a separate unit for all physicians, where requested.

VII. Other Professionals

In our original Notice of Proposed Rulemaking, we tentatively provided for a separate unit of all professional employees, excluding registered nurses and physicians, in acute care facilities having over 100 beds. We noted that section 9(b)(1) of the Act mandated separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with non-

professionals. In view of the provision for separate RNs' and physicians' units, it was and continues to be necessary to provide for a separate unit of professionals excluding these two classifications although, as noted *supra*, we have decided to abandon the proposed 100-bed differentiation.

A number of so-called "other professionals" appeared in person at the hearings to testify. In general, they confirmed the lack of interest which RNs exhibited towards their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. (Indelicato, social worker, 3673, 3678; Ahmed, laboratory technologist, 3705-06; Crisafulli, pharmacist, 3711, 3737.) In a comment, physical therapists expressed a preference for their own separate unit, but if placed with other professionals they would prefer that unit did not include RNs (Comment 134). Some fear was expressed that, because of their numbers, RNs (and also technicals) would overwhelm the other professionals if included in the same unit with them (Ratner, 3731-32; WS Cornfield, Table 1).

A number of "other professional" classifications work relatively independently, and have no immediate direct supervision (Ratner, 3735). They generally work the day shift, on weekdays (Indelicato, 3681), though some work on other shifts (see, e.g., Comment 275, Presbyterian Hospital). As a group they have high prestige within the hospital because of their superior education and training (WS Cornfield, Table 6).

Despite the desire expressed by some other professionals for their own separate units, and despite some history of separate representation of each profession, mainly in New York (see, e.g., Friedman, 5038), it seems clear to us that to provide for such additional units might create the proliferation which Congress meant to avoid. Moreover, despite the existence of some units combining technicals with other professionals (see, e.g., Willman, 4480, 4483, 4485, 4486; Shea, 5208; Robfogel, Chi. II, 224), Sec. 9(b)(1) of the Act prohibits such a combined unit, unless the professionals separately vote for inclusion with the non professionals. Accordingly, based on the above, we affirm the appropriateness of a separate unit of all professional employees, other than RNs and physicians.

VIII. Technicals

A. Introduction

In our Notice of Proposed Rulemaking, we tentatively determined that technical employees constituted a separate appropriate bargaining unit. Among the reasons we expressed were:

(a) That, in comparison with other non-professionals, they typically have significantly higher levels of skill and training, and are paid substantially more;

(b) That it has been the Board's consistent practice to approve separate units of technical employees; and

(c) That these separate units generally have met with approval from the courts of appeals.

After carefully considering the evidence presented during the rulemaking proceedings, we have determined that technical employees appropriately constitute a separate bargaining unit.

B. *Technical Employees Are Separate and Distinct From Other Non-Professional Employees*

1. *Education, licensing, training, and skills.* Technical employees are found in major occupational groups including: medical laboratory, respiratory therapy, radiography, emergency medicine, and medical records.²³ (WS McKinney, 2.) The evidence presented at the hearings demonstrates that technical employees perform jobs involving the use of independent judgment and specialized training, as opposed to service and maintenance employees who generally perform unskilled tasks and need only a high school education (AFL Br. 32, citing *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985); McKinney, 5502-03, 5523-24; Colbert, 5020; WS Shea at 20). Testimony indicated that the gap between technical employees and service and maintenance workers actually is widening, with higher levels of technical skills more closely aligned to professional job categories rather than to other non-professional categories (WS Shea at 20; WS

²³ Although we note that historically, those employees who enter and decode patient data in medical records have been placed in service and maintenance units or overall non-professional units (see e.g., *Levine Hospital of Hayward*, 219 NLRB 327 (1975); *Duke University*, 226 NLRB 470 (1976)), the inclusion of "medical records technicians" in a separate technical unit may be litigated as a unit placement issue when it arises, on a case-by-case basis.

Schoen at 14 and 5175-76). Thus, technical employees occupy a high-prestige status distinct from other categories of non-professional employees because of the training requirements for their jobs (WS Cornfield at 12-13).

Technical employees further are distinguished by the support role they play within the hospital, and by the fact that they work in patient care. Examples of their work include: routine clinical tests performed by medical laboratory technicians; general respiratory care administered by respiratory therapists; and x-rays, ultrasound procedures, and CAT scans performed by various technicians. (WS Briguglio at 3.)

Contrary to the AHA's statement that "no evidence of separate or distinct employment attributes of technical employees was presented at the hearings" (AHA Br. 33), the evidence shows that all health care technical employees have significant additional education and/or training beyond high school, including: community college associate degree programs which provide math and science background beyond that which high schools offer (WS McKinney at 5); vocational training programs run by hospitals (WS McKinney at 7); programs at accredited schools of technology (WS Briguglio at 2); and, in some fields, a full 4-year college degree (Schoen, 5176; McKinney, 5477).

Further, the evidence indicates that most hospital technical employees are either certified (usually by passing a national examination), licensed, or required to register with the appropriate state authority (Willman, 4474), although laws regarding such licensure, registration,

training and qualifications vary throughout the country (Ahmed, 3709-11).

There was evidence that some deskilling is occurring in the technical categories, reducing the need for higher skills in operating some equipment; however, the evidence further shows that it is not across-the-board (McKinney, 5485). Further, hospitals must purchase expensive and complicated equipment to deskill a task (McKinney, 5486); and where, for example, a technologist's work may be deskilled, it then would be performed by a technician rather than by a service worker (McKinney, 5513-14; Berliner, 5633-34).

2. *Wages, hours, and working conditions.* Although, in general, hospitals apply similar benefit and labor relations policies to technical and other non-professional employees, the evidence shows that the wages and hours of technical employees differ significantly from those of the other non-professionals (Mass. Hospital Assn., Comment 105). Technicians were shown to occupy the middle ranks in the hierarchy of health care workers, and the evidence presented regarding hospital pay scales reflects this standing (WS Schoen at 15). On the average, technicians earn \$2,000 per year more than service workers in this industry (WS Schoen at 15, Table 1; Henry, 3084-85). While the wages of service workers are tied to the unskilled labor market, and those of business office clericals and skilled maintenance workers are similar to those of comparable jobs outside the industry, technicians' wages are tied to the earnings of the more highly skilled technologists with whom they work, and they generally earn approximately 75% of what the technologists earn (WS McKinney at 12-13, & 5479). Thus, management

needs to provide higher entry wages for technicians than for service workers (Shea, 5238-39; Briguglio, 5300-01; Henry, 3084-88).

Technical employees work daytime hours, with evening, night, and weekend skeleton crews, while business office clericals work daytime hours and service and maintenance employees are staffed on a 24-hour basis (Colbert, 5016-17).

3. *Supervision.* The evidence indicates that technical employees usually have separate supervision from other non-professional employees; however, this may differ from facility to facility. For example, a supervisor of some technical employees may also supervise business office clericals; or a laboratory manager who supervises technical employees also may supervise some service and maintenance employees. (Mass. Hosp. Assn., Comment 105; Briguglio, 5300.)

4. *Contact with other employees.* Technical employees typically perform their work in laboratories or in technical departments, and not in patient care areas (AFL Br. 41; Booth, 3693), although the AHA's brief states that more hospitals are beginning to locate some laboratory facilities in patient care areas and technicals may have direct and continuing involvement with other categories of employees as well as with patients (AHA Br. 33). The tasks that technicals perform, such as processing and reviewing patient specimens, taking x-rays, EKGs and EEGs, are considered ancillary services, diagnostic in nature (AFL Br. 41). Technicals have no contact with business office clericals, and only minimal contact with service employees, but in a typical laboratory, work with

doctors, technologists, clericals, and messengers (WS Briguglio, 4-5; Colbert, 5017-18; AHA Br. 33). The evidence shows that LPNs do work in patient care areas and provide direct patient care; however, the Board has found them to be appropriately included with technicals in light of their skill level and the requirement that they be licensed (AFL Br. 41 citing NLRB Exh. 5, revised).

5. *Cross training.* There is no temporary interchange, and little permanent interchange between technical employees and other non-professionals because of the difference in skills, the specialized functions of the technicals, and the differences in their education (Shea, 5221-22). Service workers typically have only a high school education or less and cannot be placed in technical positions in the absence of elaborate training programs (McKinney, 5481). Contrary to statements of industry witnesses who maintain that a service worker could take a six-week training program and be able to read EKG equipment (King, 5488), we are persuaded that technical training requires full or nearly fulltime education, and a high school education does not provide the mathematics and science background necessary (WS Shea at 21).

The evidence shows that cross-training programs are being offered at some hospitals and colleges; however, training programs and funds to provide classroom instruction for hospital employees are rare in hospitals that are not unionized (Schoen Supplemental Statement). Thus, the majority of cross-training that occurs is among the technical categories themselves (LPNs doing EKG work formerly done by EKG technicians; medical technologists administering blood gases previously administered by respiratory technicians) (St. Anthony's Health Corp.,

Comment 142; St. Joseph Mercy Hospital, Iowa, Comment 243). Moreover, new technology has brought about a decline in technician jobs requiring only minimal training, while increasing the need for more intensely-trained technicians, thus widening the gap between technical employees, who are becoming more skilled and sophisticated, and service and maintenance workers (WS Schoen, 14-15; WS Shea at 21).

6. *Career paths and the labor market.* Technical employees have a separate career path and labor market. They do not seek to transfer into other types of non-professional jobs; rather, technicians may seek to become technologists in the same line of technical work; or LPNs may seek to become RNs. (O'Cleireacain, 5426; Ryan, 4738-39.) While some LPNs may become RNs through training programs, progression to technologist is more difficult for technicians because of the 4-year college requirement for many technological positions (WS Schoen at 15; McKinney, 5477). Their existing training is not considered a "building block" toward technologist status, without successful negotiations with licensing and accreditation boards (Schoen, Supplemental Statement). Thus, in addition to little mobility in their immediate workplace, it is also difficult for technicians to move out of that workplace. As long as they wish to practice their specialties, they must remain in the health care industry. (WS McKinney at 12.) Statistics show that 100% of job placements from technical programs are in health care occupations (Ryan, 4744). In contrast, business office clericals and skilled maintenance workers have great mobility outside the industry, as do unskilled service employees (O'Cleireacain, 5427; Marshall, 4018-19).

Evidence presented at the hearings shows that the labor market for technicians, which until recently was expanding steadily, is contracting (McKinney, 5474, 5478). Witnesses testified that with the introduction of cost containment techniques into the industry, the future of technical workers is in a state of flux. Further, even though new technology and equipment continue to be developed, at the same time hospitals are seeking to save on labor costs by replacing expensive, skilled employees, closing laboratories, and contracting out laboratory services. (WS McKinney at 13; Berliner, 5598.) Certificate of Need programs impose limits on the addition of new technology, further reducing the need for new technicians. For all of these reasons, training programs have become an important bargaining issue. (Schoen, Supplemental Statement.)

C. *Organizing and Bargaining*

The health care industry's bargaining unit proposals in 1973-74 would have allowed a separate unit for technical employees in hospitals (AFL Br. 31); and since 1974, the Board has continued to find separate technical units appropriate (NLRB Exh. 5, revised; *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985)). As we noted in our proposed rule, court decisions have approved the Board's determinations as to technical units. See, e.g., *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB v. Sweetwater Hospital Association*, 604 F.2d 454 (6th Cir. 1979). See also *Vicksburg Hospital v. NLRB*, 653 F.2d 1070, 1075 (5th Cir. 1981). Further, the evidence shows that technicals choose to organize in technical groups and not with other non-professionals

(Booth, 3686-88). In the 588 hospitals in which a union affiliated with the AFL represents at least one bargaining unit, there are 311 separate technical units (including LPN units), and only 52 units in which technical employees and other non-professionals are combined into a single bargaining unit (AFL Br. 44 and Appendix A; Booth, 3688-90). In addition, LPNs organize with technicals who have the same training, education, licensure, and certification requirements (Muehlenkamp, 4787).

Organizing drives are initiated by employees with specific concerns and grievances (WS Splain at 4; Sackman, 3592; Schmidt, 3628; Muehlenkamp, 4784). Other interests include professional conferences, training, and rotations (Colbert, 5019). At the hearings, no union organizer who was asked could recall any situation in which technical employees sought to include business office clericals or unskilled service workers, or vice versa (Olson, 4718; Muehlenkamp, 4784).

Technical employees generally choose to have separate initial contracts; however, they may agree, after the initial agreement expires, to engage in joint bargaining, but retain separate delegates for negotiations and for presenting separate issues (Booth, 3688; Colbert, 5021-22). Although industry witnesses maintain that the fact that technical employees organize and bargain their first contract as a separate unit does not justify finding a separate technical unit appropriate where subsequent bargaining history shows that they now bargain in broader units (St. Luke's/Roosevelt, Comment 224; AHA Br. 32-33), there is evidence that difficulties have arisen occasionally where technicals have been included with maintenance

employees and clericals because of their different training, duties, and wages (Logan, Comment 150, pp. 3-4).

D. Proliferation

Technical units generally encompass a wide range of classifications, including LPNs, and they constitute approximately 17% of the health care work force – a substantial complement of workers (WS McKinney at 2; WS Schoen at 3, 5). What evidence there is shows that strikes involving technical employees alone are rare. In New York City, for example, strikes involving technical employees occur in broader units of clericals, service and maintenance, and professional employees. (Long Island Jewish (LIJ) Medical Center, Comment 270.)

E. Other Issues

The label "technical" may no longer define a particular group of jobs, and indeed, the union witnesses who appeared at the rulemaking hearings often did not distinguish between technicians and technologists (Schoen, 5175; Ahmed, 3709-11; McKinney, 5471-79; WS Briguglio at 2-3.) Technologists often have been included as professional employees in professional-only units. See, e.g., *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976); *Mercy Hospitals of Sacramento*, 217 NLRB 765, 769 (1975). Although industry witnesses urge the Board to consider the practical effect of the difficulties of resolving issues of unit placement, and caution that there may be "intense litigation" over unit placement which could be avoided by the inclusion of technicals in a broad non-professional unit (AHA Br. 34), we note that, even with such inclusion,

litigation could continue to occur over which technicians were professional employees. Individual placement issues always have been present in the consideration of health care and other cases. In our opinion, their existence should not deter the Board from taking the first step, i.e., determining the threshold appropriateness of a separate technical unit.

F. Conclusion

For the above reasons, we determine that separate technical units are appropriate for collective bargaining. The evidence clearly demonstrates that the varied technical employees employed in the health care industry are appropriately grouped into a single unit by virtue of their education, training, and specialized skills, and do not constitute a unit so large as to be overly diversified and hence unwieldy for organizing and collective bargaining.

IX. Skilled Maintenance

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that service and maintenance employees constituted a separate appropriate unit and that skilled maintenance employees should be included in that unit rather than represented in separate skilled maintenance units. Among the reasons we expressed for including skilled maintenance employees in the broader service and maintenance units were:

- (a) That their skill levels do not, at times, greatly exceed those of other service and maintenance unit employees;

- (b) That they work throughout hospital's facilities, and thus frequently come into contact with other service and maintenance employees;

- (c) Their inclusion in broader units will help to prevent unit proliferation; and

- (d) As a practical matter, the Board's approval of separate maintenance units had fared poorly in the courts.

After carefully considering the evidence amassed during the rulemaking hearings, we have determined that, contrary to our earlier impressions, skilled maintenance employees can and should constitute a separate appropriate bargaining unit.

B. Relationship to Other Employees

1. *Functions and skill level.* Evidence from the rulemaking hearings shows that skilled maintenance employees perform functions apart from those of unskilled service, maintenance, and clerical employees in that these employees deal with highly complex and sophisticated systems and equipment (Carrick, 3448-3450; Jacquin, 5354-55; Lake, 146-148). While they occasionally perform routine, unskilled tasks, skilled maintenance employees are generally engaged in the operation, maintenance, and repair of the hospital's physical plant systems, such as heating, ventilation, air conditioning, refrigeration, electrical, plumbing and mechanical (Lake, 150-151; Viat, 3457-59, 3476-77; Hach, 5318; Giblin, 5382-83). Work on these systems requires abstract skills and knowledge at levels considerably higher than those

of other non-professional hospital employees (Marshall, 4010-4012; Hammond Exh. 1, pp. 340-45, 580-623; Cornfield, 5698; WS Cornfield at 4-6, citing Dictionary of Occupational Titles of U.S. Employment and Training Administration). Skilled maintenance employees are rated more highly, for example, even than physicians on the manipulation of "things" (WS Cornfield at 5). Skilled maintenance employees are frequently required to have postsecondary training in their field, such as vocational or trade school. Even the lower skilled maintenance employees in plant operations and maintenance are required to have higher skills than those required of service employees. (Jacquin, 5363-64, 5374, 5377; Viat, 3459-60; Giblin, 5384.)

2. *Education, licensing, and training.* Contrary to virtually all nonsupervisory service classifications, which require only a grade school education, skilled maintenance classifications require completion of high school; at least some trade or vocational school experience, if not graduation therefrom; completion of formal or informal apprenticeship programs, which may take several years; or an associate's or bachelor's degree (Hammond, 5404-05, 5409-12; AHA Health Care Occupations: A Comprehensive Job Description Manual pp. 340-45, 385-88, 394-402, 499-501, 561-62, 567-70, 573-74, 580-623; Marshall, 4010). Skilled maintenance employees also need continuing education to keep abreast of technological changes in building maintenance, such as computers and remote controls (Carrick, 3454; Marshall, 4011-12; Schloop, Chi II 165; Schwemm, Chi II 186-89; Hammond, 5408; WS Schwemm, Exh. 5-9; WS Fowler at 4; WS Denevi at 7-9). Moreover, the amount of training available in

skilled maintenance classifications compares favorably to that offered in various technical classifications, such as lab technician and medical records technician (WS McKinney at 6-7), and access to the programs and the upward mobility they bring provide a common concern to employees largely unshared by those outside the skilled maintenance group (Schloop, Chi II 165; Ryan, 4739). Another distinction between skilled maintenance and unskilled service employees is that at least seven skilled maintenance classifications, but no service classifications, require licenses. (Hammond, 5404-06; WS Cornfield, at 6-8)

3. *Supervision.* The distinct nature of skilled maintenance functions is underscored by the frequent placement of skilled maintenance employees in separate departments, usually coinciding with the hospitals' plant engineering or maintenance departments (Carrick, 3448; Viat, 3457, 3478; Marshall, 4014; Hach, 5342, 5354). Thus, skilled maintenance employees frequently have their own supervision (Hammond, Exh. 1, pp. 581-590). Moreover, skilled maintenance employees are not supervised by any supervisors from outside their own departments (see, e.g., WS Fowler at 8).

4. *Wages, hours, working conditions.* While it appears that certain terms and conditions of employment, i.e., fringe benefits and personnel policies, are similar among non-professional employees (Jacquin, 5368-70; Comer, Chi II 326-29; Comment 129, Hall), wage rates paid to skilled maintenance employees underscore their higher skills and training. Thus, the most recent Industry Wage Survey: Hospitals, Aug. 1985, BLS of the DOL, shows that skilled maintenance employees in private hospitals in 23

metropolitan areas averaged \$11.89/hour whereas, in comparison, employees in six service classifications averaged \$6.84/hour, office clericals in five classifications averaged \$7.56/hour, and employees in ten technical classifications averaged \$9.89/hour. (Lake, 154-55; IUOE, Exh. 4.) Thus, on the average, skilled maintenance employees earn 25% more than technicians, almost 60% more than business office clericals, and 76% more than service employees. Moreover, the wage rate of lesser skilled maintenance employees, while lower than that of the most skilled maintenance employees, almost always exceeds that of even the highest-paid service employees and often exceeds the rate of employees in other classifications as well.

5. *Interaction with other employees.* Though they primarily work in maintenance areas, skilled maintenance employees do perform work throughout the hospitals (Kelly, Chi II 178; Carrick, 3453; Hach, 5330). As a result, skilled maintenance employees have contact with just about every other employee in a hospital. However, these contacts are brief, limited, and incidental as it appears that the only employees with whom skilled maintenance employees actually work are others from the maintenance department (Carrick, 3453-54; Jacquin, 5360; Kelly, Chi II 212-13), and that the contacts with nonmaintenance employees typically consist of other employees' identifying the maintenance problem to the skilled maintenance employees (Kelly, Chi II 178, 213; Jacquin, 5360; WS Fowler at 8).

6. *Labor market and career paths.* Skilled maintenance employees have separate labor markets and highly mobile cross-industrial career paths as the operation and

maintenance of physical plant systems are the same no matter in which industry they are performed (Marshall, 4014; Schloop, Chi II 163; Kelly, Chi II 177; Fox, 3436-37; O'Cleireacain, 5427; WS Denevi at 4). Easy mobility in skilled maintenance classifications tends to orient these employees toward their skills rather than the industry in which they are employed (Lake, 144, 490; Marshall, 4010, 4019). The external skilled maintenance labor market also affects the hiring and wage scales in the health care industry since hospitals compete with other industries, such as hotels and office buildings, for these employees (Berliner, 5645; Hach, 5344-45; WS Schoen at 23; Corbett, 3344-45).

Skilled maintenance employees are in a separate internal labor market within the hospital in terms of career path, training, and promotion. There are formal and on-the-job training programs to permit lower level maintenance employees who have acquired skills and knowledge to move into more highly skilled positions; yet, there is virtually no transfer of clerical or service employees into maintenance classifications. (Schloop, Chi II 204-05; Kelly, Chi II 216-17; Giblin, 5400; O'Cleireacain, 5427, 5468; WS Shea at 18.) Even entry level jobs are filled by those with skilled maintenance backgrounds (Hach, 5327; Schloop, Chi II 203-04).

C. *History of Representation*

The appropriateness of separate skilled maintenance units is supported by a history of separate representation, especially by labor organizations specializing in the separate representation of skilled maintenance employees

(IUOE Exh. 2 revised; Holland, Chi II 305-09; Friedman, 5036, 5040-41; Peters, Chi II 131-34; Comer, Chi II 320, 327-28; Hach, 5328; Giblin, 5395). For example, the IUOE currently represents at least 237 separate skilled maintenance units in both private and public health care institutions nationwide (IUOE Br. 56). Twenty percent of IUOE health care units date from the 1940's and '50's, and 85% of them predate the 1974 amendments (IUOE Exh. 2 revised). Admittedly, there are skilled maintenance employees represented in combined service and maintenance units, or in a handful of broader non-professional units, but inclusion of skilled maintenance employees with these other employees does not necessarily show a voluntary grouping as some combined units are the result of stipulations so that elections could be held without further delay, or are atypical situations (Stickler, Chi I 16-26; Twomey, 131-34; Emanuel, 3497; Ratner, 3728; AHA Exh. 4-9; Willman, 4491-92; Muehlenkamp, 4767; Friedman, 5041; King, 4244, 4249, 4251-52). In addition, the evidence regarding combined units is equivocal in that the "maintenance" employees in "service and maintenance" units are frequently unskilled rather than skilled maintenance employees (Silberman, 5651; IUOE Br. 58; Shea, 5227-28; Splain, 5302-04).

D. Organizing and Bargaining Interests

1. *Organizing.* Though clearly not impossible, it appears that because of the variety of personal interests involved it is more difficult to organize larger, combined units than to organize separate smaller units of employees (Viat, 3465; Sackman, 3578; Schwarz, 265; WS Schwarz, Koziara study p. 1, 4, Figure 1; Delaney,

4517-18, 4525; Silberman, 5686; AFL Exh. 2). Larger heterogeneous units deter decertifications of unions as well (Delaney, 4523). In addition, skilled maintenance employees usually do not wish to organize with other groups, and it is unusual for different groups of non-professional employees to seek to organize in the same unit (Muehlenkamp, 4785; Olson, 4698-99; Ratner, 3730). There is evidence that, where combined units are sought, separate interests of the diverse groups may make it difficult, or impossible, to hold organizing meetings of the entire group (Viat, 3465).

2. *Bargaining interests.* While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, skilled maintenance employees have additional interests different from those of other non-professional employees. They seek wage levels commensurate with those of skilled maintenance employees in other industries; access to craft-related education and training programs; tool supply allowances; safety equipment and practices; portable pensions, because of their cross-industrial mobility; and input with respect to subcontracting of work. (Kelly, Chi II 175; Marshall, 4011; Willman, 4492-93; Schloop, Chi II 164-65; Schwemm, Chi II 209; Viat, 3466-67; Giblin, 5388.) Service employees and business office clericals have specialized bargaining interests as well (Schloop, Chi II 168; Viat, 3466-67; Gregory, 5746). These differences lead to difficulties in bargaining in a heterogeneous group, and may result in the smaller group of skilled maintenance employees getting lost in the shuffle in negotiations relating to the more numerous lesser skilled employees (Schloop, Chi II 168-69; Olson, 4729-30; Viat, 3465; Willman, 4492; Ratner, 3734; Shea,

5187; Meuhlenkamp, 4795-96). Negotiating in a broader unit may also serve to broaden the scope of labor disputes by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466). For example, in one hospital in which two unions jointly represented a combined unit of service, skilled maintenance, technical, and plant clerical employees, the skilled maintenance employees were forced to join other employees in a strike over unresolved bargaining issues that affected only the other employees even though all issues involving the skilled maintenance employees had already been settled (Viat, 3466).

E. Proliferation

Contrary to our concern, as expressed in our NPR, there was no evidence adduced at the rulemaking hearings that establishing a separate unit of skilled maintenance employees will lead to proliferation of bargaining units in the industry (Kelly, Chi II 180; Gilmore, 4894; Splain, 5252). No labor organizations have sought or demonstrated the appropriateness of other small units (IUOE Br. 64-65). Moreover, the skilled maintenance employee unit may be viewed as a consolidation of specialized employees inasmuch as it combines such employees as carpenters, painters, plumbers, and electricians (IUOE Br. 65). The only employee classification performing work similar to that performed by traditional craft or trade-type maintenance employees are biomedical technicians (Marshall, 4018-20; Hach, 5346-49; Jacquin, 5377; Viat, 3480-81; Giblin, 5396-98). Biomedical technicians work on and repair sophisticated computer-based

equipment, and because of both their skills and training share a community of interest with other skilled maintenance employees and in many instances have already been included in some such units (Fox, Exh. 1 and 2; Hammond, Exh. 12; Viat, 3458, 3460, 3480; Giblin, 5495-97; Marshall, 4019-20; McKinney, 5497, 5525; Hach, 5347-49; Jacquin, 5377; Schloop, Chi II 203-04; Carrick, 3448).

F. Strikes, Sympathy Strikes, Jurisdictional Disputes, and Wage Leapfrogging or Whipsawing

1. *Primary strikes.* The evidence taken at the rulemaking hearings shows that the presence of separate skilled maintenance units has not resulted in a large number of strikes by these units (Lake, 157; IUOE Exh. 2; Viat, 3468; Schloop, Chi II 169; Kelly, Chi II 180; Hach, 5323; Giblin, 5389; Hammond Exh. 12, attached affidavits). The hospitals contend that the number of strikes is low because the number of employees involved is small and therefore the cost of a strike exceeds the potential increase in labor costs of the union's demands thereby making it more likely that hospitals will give in to those demands. Nonetheless, the fact remains that in the 237 skilled maintenance units represented by the IUOE, in which hundreds of contracts have been negotiated, there have been only about 25 strikes ever (Lake, 157; IUOE Exh. 2). In addition, the incidence of strikes by skilled maintenance employees has not increased in proportion to the number of other represented units of hospital employees (IUOE Exh. 2; Viat, 3468-69; Fox, 3442). The few strikes that have occurred have been almost exclusively in support of bargaining demands, and have not

been disruptive to health care delivery; indeed, skilled maintenance employees have offered to provide skeleton crews to assure uninterrupted service in the event of a work stoppage (Henry, 3059; Fox, 3442; Viat, 3467-68, 3470; Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb.) Moreover, other hospital employees, whether represented or not, generally have not engaged in work stoppages in support of striking skilled maintenance employees (Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb).

2. *Sympathy strikes.* While the strike rate in the health care industry in general is low (Subrin, Chi I 119-20; Schoen, 5181; Silberman, 5659), there is evidence that hospitals have not availed themselves of the opportunity to limit the possibility of successive multiple strikes by supporting union proposals for common contract expiration dates of different units' contracts; indeed, hospitals have opposed such proposals. (Henry, 3075; Absalom, 3318-19; Corbett, 3359-60; Schmidt, 3625; Weinrich, 4274; Muehlenkamp, 4771, 4774). Moreover, there have been virtually no sympathy strikes by skilled maintenance employees in support of other striking hospital employees (Schloop, Chi II 169; Kelly, Chi II 180; Fox, 3442; Friedman, 5060; Hach, 5323; Jacquin, 5361; Giblin, 5389; WS Fowler at 7; Hammond Exh. 12, affidavits of Bess, Tighe, and Chambers). No-strike clauses, which are generally honored, appear to have contributed to the infrequency of such strikes (Fox, 3442; Friedman, 5060-61). And, while the evidence shows that bargaining in broad, heterogeneous groups may serve to expand the scope of a strike by involving employees whose personal interests are not of concern in disputes relating to the

interests of other unit employees (Viat, 3466; see above discussion in subsection (d)(2), Bargaining Interests), it also shows that the absence of sympathy strikes in the industry makes it unlikely that such expansions of strikes will occur where employees with separate and distinct interests are represented in separate units.

3. *Jurisdictional disputes.* In general, industry witnesses were unable to support the allegation that allowing separate skilled maintenance units would increase the number of jurisdictional disputes in the industry (Graumann, 409; Weinrich, 4254, 4281; Cammarata, 4406). Instead, the evidence shows that jurisdictional disputes over work assignments involving skilled maintenance employees are, like those in the hospital industry in general, rare and nondisruptive (Roth, 3153; Muehlenkamp, 4775; WS Shea at 14). Moreover, we are persuaded that the types of jurisdictional disputes which do arise, i.e., disputes over job classification, content, and responsibility, occur regardless of whether the employees are represented in one unit or several different units (Krasovec, 420-22; Hach, 5324; Giblin, 5389-90; WS Shea at 14). Finally, the few disputes which have arisen have been resolved informally, minimizing disruption of normal operations (Schloop, Chi II 170-71; Kelly, Chi II 181, 206, 207; Fox, 3442-43 & Exh. 2; Viat, 3471; Hach, 5323; Jacquin, 5361; Giblin, 5389).

4. *Wage whipsawing and leapfrogging.* Wage whipsawing or leapfrogging virtually never occurs with skilled maintenance units inasmuch as the wages of skilled maintenance employees are generally based on the wages of skilled maintenance employees in other industries,

rather than on the wages of other health care industry employees (Corbett, 3344; Hach, 5344-45).

G. Changes in the Industry

The alleged trend toward specialized hospitals and integration of employee functions would appear to have no impact on skilled maintenance units because the physical plant systems will essentially remain the same and will require skilled maintenance employees to operate and maintain them (Viat, 3470). Any move toward interdisciplinary teams also appears to have had no effect on skilled maintenance employees as virtually every team that was described by the industry included only health care personnel (Mixon, Chi II 275; Gallagher, 3541-42; Houston, 4025, 4050-55; Donnelly, 4064, 4080; Sokatch, 4195; Weinrich, 4268-69; Comment 62, Achterhof; Comment 78, Olman Greater Cincinnati Hospital Council). The one example provided at the hearings of skilled maintenance employees' participating on a team involved the skilled maintenance employees' voluntarily critiquing vocational training projects of rehabilitation patients (Coney, 165). This one example of an incidental function undertaken by a maintenance group at one hospital is, so far as we know, unique, but in any event does not involve direct patient care and is clearly insufficient to obliterate their distinct functions. Finally, the industry gave no examples of skilled maintenance employees being cross-trained into other job groups such as clericals or service employees and, cross-training from service to skilled maintenance positions or technical positions is virtually unknown. (Stickler, Chi I 9, 33-37; Houston, 4026; O'Cleireacain, 5467-68; McKinney, 5481.)

H. Other Issues

1. *Costs of multiple units with reference to skilled maintenance.* Assuming the relevance of the potential cost to the industry of negotiating in additional units, the evidence does not support the conclusion that units of skilled maintenance employees would necessarily have any adverse effect on hospitals' expenses. The evidence there is shows that contract negotiations for skilled maintenance units tend to be relatively short, which means relatively inexpensive (Comer, Chi II 328; Viat, 3469; Jacquín, 5378).

2. *Congressional admonition against proliferation.* The admonition against proliferation of units was directed toward problems that could be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. As shown above, there is little or no evidence that the existence of separate skilled maintenance units has resulted, or would in the future result, in these problems. As a practical matter, permitting separate skilled maintenance units would not necessarily result in the creation of still additional bargaining units since most hospitals have substantially fewer organized units than the number proposed by either the Board or the unions. (Schwarz, 264, WS Table 1; Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4425; Delaney, 4520; Muehlenkamp, 4770-71; Shea, 5163.)

During the 1973 legislative hearings on S. 794, the fear expressed by a number of witnesses was that Board precedent might permit a separate unit for each trade or

craft found in hospitals. Thus, e.g., Sidney Lewine, testifying on behalf of AHA, and Richard V. Whelan, Jr., representing the Ohio Hospital Association, noted with apprehension the proliferation that would result if the Board were to grant a separate unit to each construction craft such as stationary engineers, carpenters, plumbers, electricians, pipefitters, and painters. (Coverage of Non-profit Hospitals Under National Labor Relations Act, 1973, Hearings on S. 794 and S. 2292, at 128-29, and 465-66, respectively.) The Board's proposal directly takes into account this concern, which was called to Congress' attention, by putting all such separate skilled crafts into *one* skilled maintenance unit.

3. *The most recent Board decision.* In *St. Francis Hospital*, 286 NLRB No. 123 (Nov. 30, 1987) (*St. Francis III*), the Board held that a separate maintenance unit was inappropriate. In so doing, the Board found that the hospital's maintenance employees constituted less than 10% of the hospital's 438 service and maintenance employees, and spent approximately 80-95% of their time working throughout the hospital, thus bringing them in frequent contact with all other hospital employees. The Board further found that the hospital used independent contractors to perform difficult work, and that the sought employees shared the same basic terms and conditions of employment as service employees, including departmental supervision. The Board also noted that its finding that these particular maintenance employees did not constitute a separate appropriate unit was based on the particular facts of the case and was in no way an expression of its view concerning the appropriateness of maintenance units in general. Based on the evidence obtained during

the rulemaking hearings, it is unlikely that we would reach the same result. Thus, the evidence from the hearings shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees. They perform functions apart from those of unskilled service, maintenance, and clerical employees. Skilled maintenance employees were shown to be highly skilled as evidenced by higher educational, licensing, and training requirements. While they share some common terms and conditions of employment with other hospital personnel, these employees uniformly have higher wages than service and clerical employees and have a number of bargaining interests separate and distinct from those of non-maintenance employees, such as access to craft related education and training programs, tool supply allowances, safety equipment and practices, portable pensions, and the like. Moreover, while skilled maintenance employees do work throughout the entire hospital, their contact with non-maintenance employees is brief and limited. Finally, the hearing evidence shows that transfers are rare in the industry and that skilled maintenance employees have a separate internal and external labor market.

I. Conclusion

For the above reasons, we find that a unit of skilled maintenance employees is separately appropriate for collective bargaining purposes. Although the number of employees in such a unit will be relatively small, their work bears little relationship to that of other hospital employees. It is, essentially, a non-health care occupation

involving skills, interests, and job markets largely separate from the hospital itself. For that reason, to require unions to organize and represent skilled maintenance employees as part of a larger group of unskilled employees performing health-related jobs within the hospital is both unrealistic and inefficient. Hence, we have decided that the final rule should provide for separate skilled maintenance units.

The IUOE contends (IUOE Br. 9), and we find, that skilled maintenance units should generally include all employees involved in the maintenance, repair, and operation of the hospitals' physical plant systems, as well as their trainees, helpers, and assistants. However, evidence from the hearings shows that it may not always be possible to identify in advance those employees properly included in this unit, partly because employees performing essentially the same functions are classified differently in different hospitals. Thus, for example, in Los Angeles and San Francisco all employees represented by the IUOE in skilled maintenance units are classified as stationary engineers regardless of their particular job functions (Viat, 3457-58; Hach, 5318) whereas in Chicago, New York, and New Jersey most health care employers have retained craft titles for their employees. (Schloop, Chi II 203; Schloop affidavit; Hach, 5318; Giblin, 5383.) In addition, many skilled maintenance classifications are subdivided by skill or experience level, e.g., master level, journeyman level, apprentice, and/or helper. Among the employee classifications which should generally be included in such units are carpenter, electrician, mason/bricklayer, painter, pipefitter, plumber, sheetmetal fabricator, automotive mechanic, HVAC (heating, ventilating,

and air conditioning) mechanic, maintenance mechanic, chief engineer, operating engineer, fireman/boiler operator, locksmith, welder, and utility man. (Health Care Occupations: A Comprehensive Job Description Manual, Chapter XXXII; Hammond, Exh. 12, affidavits of Bowen, Tighe, Chambers, Scheb, McWade, Scadden, Kelly, Schloop, Gindorf, Fox, Lane, Belfi, and Bess.) As noted above, sometimes relatively unskilled utility workers are included, either if they are involved in the maintenance, repair, and operation of hospitals' physical plant systems (Viat, 3460), or if they are part of a separate maintenance department. This list is not exhaustive; rather, it is illustrative of the types of employee classifications exhibiting the characteristics which the rulemaking record shows are typical of employees included in skilled maintenance units. Because of this variation, in some instances it may be necessary to decide by adjudication the unit placement of individuals in particular job classifications. However, this is also true with respect to technical and business office clerical units, for example. It does not defeat the basic appropriateness of the unit as found in this rulemaking proceeding.

X. Business Office Clericals

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that business office clericals should be included in a unit of service and maintenance employees, rather than represented in a separate unit. 52 FR 25147. Among the reasons for including business

office clericals in the broader service and maintenance unit were that they:

(a) Often share many terms and conditions of employment with service and maintenance employees;

(b) Have regular and frequent contact with service employees;

(c) Are engaged in recordkeeping as are ward clericals, technicians, nurses, and physicians;

(d) Have not been represented historically by labor organizations specializing in representing business office clericals; and

(e) Their inclusion in the broader unit will help unit proliferation.

After carefully considering the evidence amassed during the hearing, contrary to our tentative determination we have concluded that for the following reasons the business office clericals constitute a separate appropriate bargaining unit.

B. The Record Supports a Finding That Business Office Clericals Constitute a Separate Appropriate Unit

1. *Job duties and functions.* Evidence from the rulemaking hearings shows that although many hospital employees perform some recordkeeping functions, business office clericals perform substantially different functions from those performed by other employees (WS Holtz at 8-9; WS O'Neil at 1 & 5526-29). Business office clericals are primarily responsible for a hospital's financial and billing practices (WS Winn at 6-7), and deal with

Medicare, DRGs, varying price schedules, multiplicity of insurance types, and new reimbursement systems (WS Schoen at 9; Berliner, 5599-5600). Increasing computerization of financial management has led to specialization and has reduced the clerical duties of other hospital employees (WS Schoen at 11).

One argument advanced by some employers is that many different professional and non-professional classifications use computers; 2/3 of the hospitals are considering information systems-technology which will enable nurses to enter and read programs reporting patients' test results, medication, and scheduling (AHA Br. 45 citing article in *Modern Healthcare*). Unlike these employees, however, business office clericals do not engage in any form of patient care and are not responsible for the patients' physical or environmental health (Wilkinson, 4973-76; Bryant, 116-118). Moreover, although other clerical and professional employees may be utilizing information systems technology and video display terminals (VDTs), and despite the existence at the University of Alabama (Birmingham) of a training program for "clerical technicians" who learn to do billing, perform blood tests, and take x-rays (AHA Br. attachment 5), it has not been shown that service workers or clinical technicians perform functions similar to those performed by the business office clericals, i.e., they are responsible for selecting, completing, or interpreting business forms using computers, keyboard terminals, and typewriters. Nor was it shown that the University of Alabama program was duplicated elsewhere in the country, or that any person from the program was ever placed in a hospital. (AFL Br. 77). Moreover, the evidence indicates that this program

was clearly intended for technical employees (Stickler, Chi I 37-38).

2. *Education.* Business office clericals generally are required to have a higher level of education than service and maintenance employees, i.e., a high school diploma and specific clerical skills, and a majority of business office clericals have some college background and formal clerical training (WS Nussbaum at 2; WS Cornfield at 6). Moreover, because of the increased complexity of the hospitals' financial operations, including the introduction of DRGs, hospitals have begun to require more training for business office clericals, and to require skills in such areas as programming, coding, abstracting, and billing procedures (WS Schoen at 9; WS Ryan at 1-2). By contrast, service workers have minimal educational requirements, prior work experience is unnecessary, and they are not required to possess special business-oriented skills (AFL Br. 53; WS Cornfield at 8). There is some evidence that admitting clerks and medical records librarians receive vocational training at many of the same business or trade schools as purchasing clerks and accounts receivable clerks (WS Coney at 5). However, no specific evidence was provided regarding the type of training each receives. The fact that some employees are attending the same schools does not establish that they are receiving identical training. Consequently, we do not place great weight on this factor; in any event, whether some of these other classifications are also business office clericals is a matter we do not here decide. Further, business office clericals undergo constant retraining to update current skills or acquire new skills as financial operations are updated (WS Holtz at 5, 9-10).

3. *Terms and conditions of employment.* Although clericals often share some terms and conditions of employment with non-professional employees, especially benefits, evidence from the rulemaking proceeding clearly shows other, significant differences between the business office clericals' terms and conditions of employment and those of the service and maintenance employees. Salaries paid to business office clericals reflect their higher skills and training; a 1985 BLS wage survey shows that business clericals on average earn \$2,000 more than the top service jobs (WS Schoen at 12; WS O'Neil at 3). Unlike service and maintenance employees, business office clericals may be permitted to smoke and eat at work stations, and have different dress requirements and health and safety concerns. In addition, unlike most service employees who work varying shifts and weekends, business office clericals generally work one shift, 5 days per week. (AFL Br. 59; WS Nussbaum at 5; Bryant, 116-118; Booth, 3686; WS O'Neil at 2.)

4. *Supervision.* The differences in skills and functions are underscored by the separate supervision of business office clerical departments, which has resulted from the almost universal centralization of business office functions (Berliner, 5597; WS Schoen at 9-10 & 5173). The SEIU survey of 250 facilities showed that at 100% of the facilities, business office clericals have separate supervision. Although clericals occasionally may share supervision with other non-professions (Briguglio, 5300), the evidence establishes that business office clericals regularly have a separate supervisory hierarchy; ultimate supervisory responsibility generally rests with financial administrators as compared to the ultimate supervisory

authority for service employees which rests with administrators overseeing patient care (WS O'Neil at 2; WS Holtz at 4, 6-7). Two examples were given in which clericals and other employees report to the same individual (Briguglio, 5300; Comment 157, Halifax Medical Center). Nevertheless, we are persuaded that, with a few exceptions, business office clericals are separately supervised. Moreover, in one important respect, the nature of the supervision received by the business office clericals is unlike the traditional supervision received by service and maintenance employees. Technology enable supervisors to monitor closely the output of the business office clericals, measured in keystrokes, paper output, volume of bills processed, time on terminals, and phone calls; this monitoring increasingly is used for purposes of discipline. (WS Holtz at 6-7; WS Nussbaum at 2-3.)

5. *Interaction.* Contrary to our original impression, the evidence shows that business office clericals are physically isolated from other non-professional employees and, therefore, have little contact or interaction with them. (Dretchan, 5002; Bryant, 116-118; Booth, 3689-90; WS Nussbaum at 4). The ballooning costs of new construction, as well as increased technology, have resulted in many instances in hospitals' moving administrative offices outside the health care facility into existing buildings at other locations (Berliner, 5602; WS Schoen at 10). Of 250 hospitals surveyed, 35% of the business offices are located in a separate building, 25% are located in a separate wing of the hospital, and 28% are located on a separate floor (WS Shea at 17; WS McKenna at 3-4). Further, centralized processing of information and the increasing use of computerized communication of data

continue to reduce even further the potential for physical interaction (WS Schoen at 14).

6. *Career paths and job mobility.* Business office clericals have few avenues of advancement within health care facilities; rather, they have a separate and increasingly well-defined external labor market (Wilkinson, 4980; WS Ryan & 4749-50). Business office clericals are hired almost exclusively from the external labor market, and hospitals hire business office temporaries as replacements rather than using other hospital personnel. The external market also influences salary scales since hospitals compete with other industries for these employees. (WS Schoen at 11-12; hospitals use BLS wage surveys in determining salaries for business office clericals.) Consequently, while service employees generally remain in health care facilities (WS Berliner at 9-10), business office clericals look elsewhere for other positions if they are dissatisfied.

There is minimal interchange, either permanent or temporary, between employees in service, maintenance, technical or professional jobs and those in business office clerical positions (Ryan at 1-2). Moreover, although one witness testified generally that some clericals receive training to provide direct patient care (Stickler, 16-17 & WS Rhodes at 7), there were no examples of instances where this had actually occurred. There would appear to be little cross-over from clerical positions to patient care positions. Further, the evidence reveals that job mobility between service employees and business office clericals is basically nonexistent and, with the upgrading of skills and additional training received by business office clericals, it is becoming even less feasible (WS Lewis at 2-3; WS Blake at 2; WS O'Neil at 2; WS Berliner at 7). In some

hospitals, admitting clerks and medical records librarians, and purchasing clerks and accounts payable clerks are interchangeable and may substitute for each other, and technicals and professionals may handle clerical operations on the night shift (WS Coney at 5; Comment 263, Huntsville Memorial Hospital). Nevertheless, for the most part, even clinical clerical workers cannot shift into business office clerical positions without a substantial degree of retraining and reskilling (WS Berliner at 7). There was testimony that hospitals prohibit or discourage bidding between the business office clerical and service and maintenance positions; however, even where hospital-wide posting of vacancies is required and employees use their seniority to bid, there is little cross-over between service and maintenance employees and business office clericals (WS Shea at 18; WS Roitman at 1.)

7. *History of representation.* The appropriateness of separate business office clerical units is supported by a history of representation separate from service and maintenance employees. For example, at 250 hospitals surveyed by SEIU, business office clericals sought representation in 71 hospitals, of which 46 were separately organized, compared with service employees who organized in 195; a survey conducted by NUHHCE of 200 post-1974 elections in 100-plus bed hospitals showed 37 involved business office clericals, of which 33 were separate units (WS Shea at 15-16; Muehlenkamp, 4767-70). There are 92 separate business office clerical units represented by AFL affiliates in private sector hospitals. (AFL Br. App. A). Local 1199 had no combined non-professional units until *St. Francis II* (Friedman, 5035-41). Although there are business office clericals represented in

combined service and maintenance units (Stickler, Chi I 23-31 giving examples), some combined units may have resulted from an effort to minimize delay or to comply with *St. Francis II* (AFL Br. 70). The weight of the evidence establishes that business office clericals predominantly have been separately represented.

8. *Bargaining interests.* While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, business office clericals have a number of different interests, e.g., pay equity, performance monitoring, productivity standards, career mobility, automation, and VDT stress, as opposed to concerns of service employees such as job security, subcontracting, economic survival, supplies, shift rotations, infectious disease, injuries, and patient care (WS Nussbaum at 3; WS Lewis at 2; WS Holtz at 12-13; WS Barton at 1; AFL Br. 64-65).

Despite the differences, in some instances business office clericals have bargained jointly with other non-professional employees and contracts have covered both non-professional employees and business office clericals. In 1987, Mercy Hospital negotiated a contract which included over 50 classifications in one overall non-professional unit (AHA Br. attach. 15) (One classification included such jobs as accounting clerk and lab department secretary and both received identical wage rates and wage increases for the duration of the contract). See also Comment 162, AMI; Saporta, 5142; Comment 154, Michael Reese Hospital, for other examples. However, in some cases where business office clericals negotiated together with service employees and the resulting contract provided for identical terms and conditions of employment, wages and upgrade negotiations often

remained separate, and clericals had different bargaining representatives. In one instance incentive bonuses tied to receivables were offered only to business office clericals, and in others the contracts contained separate wage schedules for business office clericals. (WS Holtz at 10; WS McKenna at 3-4.) At Roosevelt Hospital, although the union bargained jointly for clericals, technicians, and service and maintenance employees, the clericals had their own bargaining delegates, contracts for business office clericals and service and maintenance employees were administered separately, and there was no interchange of delegates or exchange of grievance handling (Colbert, 5020-22.)

9. *Proliferation.* Contrary to our concern, as expressed in the NPR, there was no evidence adduced at the rulemaking hearings indicating that a separate unit of business office clericals will lead to the proliferation of bargaining units in the industry. The admonition against proliferation of units was directed toward problems that might be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. There is no evidence that the existence of a separate unit of business office clericals would result in such problems. There were no examples of sympathy strikes by business office clericals in support of service and maintenance employees, and no examples of leapfrogging because of a separate business office clerical unit. (WS Wynn at 3.) In one hospital as to which there was testimony about separate units, there was no evidence of jurisdictional disputes. (WS Gray at 4; Michael Reese Hospital). One argument advanced was that

because a business office clerical unit will not include all clerical classifications, e.g., ward clerks, there is a potential for conflicts between clerical groups. There was no evidence of specific examples, and we accord no weight to the theoretical possibility of a conflict.

10. *Legal Precedent.* Legal precedent supports finding separate business office clerical units appropriate. The Board has recognized the appropriateness of separate business office clerical units in every other industry covered by the Act, and until *St. Francis II*, in the health care industry. See e.g., *Armour & Co.*, 15 NLRB 268 (1939); *Legal Services for the Elderly Poor*, 236 NLRB 485 (1978); and cases cited in AFL Br. pp. 71-72. From 1974-1984, the Board did not find any business office clerical unit to be inappropriate (See NLRB Exh. 5, revised). Moreover, Senator Taft's industry-sponsored bill would have explicitly provided for separate office clerical units.

In *Baker Hospital*, 279 NLRB No. 38 (Apr. 16, 1986), the Board required the inclusion of business office clericals in a unit of service and maintenance employees. In so doing, the Board found that business office clericals and service and maintenance employees received the same fringe benefits and were covered by the same personnel, salary, promotion, seniority, transfer, and disciplinary policies. The Board also found that there was a significant amount of contact between clericals and unit employees. The Board held, therefore, that there was an insufficient disparity of interests between business office clericals and service and maintenance employees to justify excluding the clericals from the unit. After considering the substantial empirical evidence adduced in the rulemaking proceeding, we find it unlikely that we would reac' the same

result. The evidence from the hearings shows that business office clericals constitute a distinct group of employees. They perform substantially different functions, have a greater degree of education and training, utilize different skills, are separately supervised, receive higher wages, have a number of distinct bargaining interests, have little or no interaction with other employees, and frequently are located in geographically separate offices.

11. *Identification of business office clericals.* The evidence from the hearings indicates that there may be other clericals, e.g., ward clericals, medical records clericals, physicians' secretaries, and admitting office clericals who perform functions similar to those performed both by service employees and business office clericals or else perform a combination of functions such that they cannot be readily classified as one or the other. To date, however, the Board has decided the placement of these categories of employees on a case-by-case basis, generally excluding these classifications of employees from business office clerical units. See *Mercy Hospital of Sacramento*, 217 NLRB 765 (1975). There, the Board found a separate unit of business office clericals appropriate, and placed ward clericals in another unit because their work was more closely related to the function performed by personnel in the service and maintenance unit. The precise placement of particular classifications which may be disputed in a particular case is, for the time being, left to the case-by-case adjudicative approach.

C. Conclusion

Business office clericals share some terms and conditions of employment with all other service and maintenance employees, have occasionally participated in joint

bargaining, and may even have been covered by the same contracts. However, we are more persuaded by the evidence developed at the hearing as to their separate supervision, their different and specialized skills and education, their minimal interchange and contact, their different career paths and job markets, their maintenance of a separate identity even where bargaining was in a larger group, and, finally, the recent development whereby more and more business office clericals are being moved out of the hospital to different buildings or facilities. We believe that the weight of the evidence strongly supports finding separate business office clerical units appropriate.

XI. Other Non-Professionals

Based on our analysis of the evidence adduced, we have found appropriate separate units of technicals, business office clericals, and skilled maintenance employees. All remaining service and non-professional employees²⁴ shall, therefore, constitute a separate appropriate unit, where requested.

XII. One Hundred Bed Distinction

The proposed rule suggested establishing a different unit configuration for hospitals over 100 beds than for those of 100 beds or fewer based on the Board's belief that hospital size (as determined by the number of beds) was correlated with integration of labor, and that smaller

²⁴ Excepting guards, of course, who must be placed in a separate bargaining unit. See section 9(b)(3) of the Act.

hospitals were more functionally integrated than larger hospitals, and could function with fewer, broader units. However, the record does not support that belief, and the Board has concluded that its rule regarding units in acute care hospitals should apply regardless of hospital size.

The vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals. Examples of unions opposing the distinction were: AFL Br. 139-140; ANA 4919-20; SEIU, 5215; Hospital Professionals and Allied Employees of New Jersey, 125. Over 40 employers registered specific or general criticism of use of a 100-bed distinction, including AHA, Br. 48; League of Voluntary Hospitals, 226-229, 254; Hospital Council of Western Pennsylvania, 4395; Comment 5, Holy Redeemer Health Systems; Comment 15, Methodist Health Systems; Comment 25, Bradley Memorial Hospital; Comment 78, Greater Cincinnati Hospital Council; Comment 82, Humana, Inc.; Comment 104, St. Francis Hospital. Experts in the field agreed with the parties' position (Rosen, 4663; McKinney, 5519-20). Only a handful of commentators supported the use of any distinction based on the number of beds. For example, Comment 11, National Rehabilitation Hospital; Comment 105, Mass. Hosp. Assn.

A survey by UFCW comparing the number of beds and the staffing in hospitals of varying sizes in five states showed a wide variation in staff size (UFCW Exh. 6-11). For example, in New York State, among 46 hospitals surveyed with 20-100 beds, one hospital with 20 beds had over 200 employees, one with 21 beds had 50 employees,

one with 20 beds had 209 employees, while another with 129 beds had 181 employees. (UFCW Exh. 11). In California, one hospital with 107 beds had 1011 employees, while another with 110 beds had 299 (UFCW Exh. 6). In Illinois, hospitals with 77 and 91 beds had 279 and 429 employees, respectively, while another hospital with 129 beds had 126 employees (UFCW Exhs. 5, 6). Similar variations, and lack of correlation, appeared throughout the exhibits.

Lack of correlation between number of beds and number of employees may be attributable to specialization or the amount of outpatient services (UFCW Exh. 1-11; WS Willman & 4500; Rosen, 4663; AFL Exh. 20). Thus, it appears that staffing size and patterns might correlate more closely with the nature of services than with bed number (AHA Br. 47; New Jersey Society for Health Care Human Resources Administrators, 439).

The AHA correctly noted that the Board's proposal for a 100-bed distinction did not clarify how it defined the term "bed" (AHA Br. 47). The record shows that there are several meanings of the term in health care facilities. A bed may be licensed or unlicensed; if licensed a bed may be occupied or unoccupied (AHA Br. 47; Comment 52, Hillcrest Baptist Medical Center). Hospitals may change the number of licensed beds more than once a year (California Association of Hospitals and Health Systems, 3229). Occupancy rates vary; a hospital may have occupancy substantially below the number of its licensed beds (Comment 1, Lancaster Fairfield Hospital; Comment 115, National Healthcare, Inc.: rural areas may have only 25-30% patient census). The number of staffed beds (based on average projected occupied beds and patient

acuity) can differ from the number of occupied beds (Comment 186, Hiawatha Community Hospital; Comment 191, Trinity Lutheran Hospital.) Beds may also include swing beds (beds that swing between acute care and nursing or long-term care) (Missouri Hosp. Assn., Chi II 265).

The Board also notes that to the extent unions and employers addressed the standard to be used if the Board determined to have a bed-number distinction, they rejected the use of 100 beds as an appropriate bed measure but did not reach a consensus as to the appropriate number of beds to use. For example, some unions suggested using the definition of small hospitals employed by the U.S. Department of Health and Human Services in calculating reimbursements under Medicare, which is those hospitals with fewer than 50 licensed beds. (AFL Br. 141; WS Sweeney.) The AHA suggested a 400-bed cutoff (AHA Br. 141), but other employers suggested 250 beds (Comment 169, Columbus Hospital); 300 beds (Comment 126, Arlington Memorial Hospital); 450-500 beds (Comment 1, Lancaster Fairfield Hospital); and 500 beds (Comment 11, National Rehabilitation Hospital).

The Board's decision to drop the 100-bed distinction is based on the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term "bed" in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the

parties' general opposition to use of a distinction based on the number of beds.²⁵

XIII. Nursing Homes

The only health care facility, other than hospitals, covered by our proposed rule was nursing homes. In so doing, we tentatively determined that the appropriate bargaining units for this type of health care facility should be the same as that for small hospitals, i.e., (1) all professionals, (2) all technicals, (3) all service, maintenance, and clericals, and (4) all guards. After careful consideration of all the evidence presented at the hearings, however, we have concluded that the rule should not apply to nursing homes.

To a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered. Generally speaking, there are three basic types of nursing home facilities: skilled nursing, intermediate care, and residential care. Skilled nursing homes provide 24-hour inpatient nursing care to chronically ill or stable convalescent patients, are state licensed, and are eligible for both Medicare and Medicaid. Intermediate care facilities also provide 24-hour inpatient care, but care is less intensive and more oriented to daily living. These homes are also state licensed or certified but are eligible only for

²⁵ We note, parenthetically, that the information we have acquired as to the relationship between staffing and number of beds most likely would not have been acquired in an adjudicatory proceeding, and provides further evidence of the value of rulemaking in obtaining industry-wide information unavailable in a case-by-case approach.

Medicaid. Residential care facilities meet only social needs, not medical, and are not licensed. (Durham, 3164-66, 69, 71, 83; Comment 155, Indiana Healthcare Assn. (IHA).) The facilities range in size from 10-500 patients (Harris, 4294; Comment 284, Ryan). One-third have a capacity for fewer than 50 residents, one-third for 50-99, and one-third for over 100 (Harris, 4304).

Unlike hospitals, nursing homes are populated primarily by the elderly and provide long-term care rather than medical treatment of a specific illness. Consequently, nursing home staff are concerned not only with their residents' physical well-being but also their social and psychological needs. Accordingly, there is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated. (Harris, 4294-95; Willman, 4501-02.) Generally, nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals (AHA Br. 6-7 citing *Modern Healthcare*, Jan. 3, 1986). In addition, RNs in most nursing homes never administer oxygen or assist in surgery, and therefore generally have no interest in or need for acute care pay differentials or for specialization (Comment 155, IHA; Shepard, 4962). Also, there is for the most part little difference in the duties of LPNs and nurses' aides (Comment 155, IHA). Both are primarily responsible for providing nursing care to patients (Comment 155, IHA, affidavits of Miller and Price; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986). Indeed, almost no aspect of nursing home care is in the exclusive domain of any one group of employees (Harris, 4295). Thus, there appears to be a greater overlap of

functions as well as greater work contact between the various nursing home non-professionals (Willman, 4501-02; Comment 155, IHA, affidavits of Townsend and Turner-Simpson).

Skilled care homes also differ from hospitals in that a ratio of 50 patients per nurses' station is ideal for nursing homes, whereas the typical ratio for acute care units is half that number (AHA Br. 7 citing *Modern Healthcare*, Jan. 3, 1966).

Also unlike hospitals, there are few professionals employed at nursing homes, and of those, most are RNs who serve as head nurses or charge nurses primarily performing administrative duties (Durham, 3190; Willman, 4501-02; Saporta, 5145-46; Bullough, 4656-57; Comment 155, IHA, affidavits of Davy, Townsend, Turner-Simpson, and Higdon). There are also few business office clericals. In a typical 100-bed nursing home, the business office will have one or two employees. In a 100-bed acute care hospital, the office consists of payroll employees, accounts receivable and payable employees, data processing employees, and others. (Comment 155, IHA).

Greater differences in the size and purpose of nursing homes have resulted in greater differences in their organization, regulation, and staffing patterns. For example, in very large homes, business office clericals may be physically separated from the home, and have little employee or patient contact. In very small homes, the business office is located next to the patient care areas and there is continuous contact with the patient care staff. (Comment 155, IHA; Durham, 3166-67). Duties of staff also vary with the size of the institution. In a small, 10-

resident facility, the staff will have overlapping responsibilities, and thus an overall unit would be appropriate. In a large, skilled care facility with specialized units (see *infra*), more than one unit might be appropriate (Harris, 4298). In an intermediate care facility which also cares for the mentally disabled as a result of trauma, there may be a separate group of employees, such as psychiatrists, who have distinct supervision and little contact with other professionals (Durham, 3170).

Although most homes are regulated by the state, regulations with respect to staffing patterns and employee qualifications vary widely from state to state (Harris, 4296-97; Comment 284, Ryan). For example, Connecticut requires more skilled nursing care than Iowa, and in some states, skilled nursing facilities must have 24-hour RN coverage. Seventeen states have mandated nurses aide training programs ranging from 20 hours to over 100 hours. A majority of states have no specific training requirements. In Massachusetts, the activity director and the social service director must have baccalaureate degrees; in other states, their formal qualifications are less than those of a nurses' aid. (Harris, 4297; Comment 284, Ryan; Comment 155, IHA.) Also in Massachusetts, as in other states, homes must be staffed by LPNs or RNs, and they are required to provide substantial direct patient care. In contrast, in Indiana, with lesser staffing requirements, nurses' aides provide direct patient care, and LPNs perform RN-type duties such as distributing medication and assisting doctors. (Comment 155, IHA.)

The nursing home industry is also in a period of rapid transition. It is currently undergoing enormous

growth as the population of older persons increases and family responsibility for older parents lessens. In addition, many long-term facilities will increasingly offer non-traditional specialized services, i.e., head and spinal cord injury units, intensive rehabilitation, sub acute care, Alzheimers, respiratory therapy, hospice care, nutrition, AIDS, home health care, and care for ventilator dependent patients. (Harris, 4299; Comment 284, Ryan; Durham, 3161; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986.) These services require different staffing needs. For example, in most Alzheimers' units, nurses' aides receive psychological training in order to respond properly to their patients' behavior, and LPNs are required to perform recreational, educational, and social activities that are normally done by service employees such as recreational aides. A head injury unit requires many more professionals than are usually present in a nursing home facility. An AIDS facility might need more counselors. (Harris, 4300-4301; Comment 284, Ryan.) The professional and technical staff in a specialized service area such as a coma unit may also be far more integrated than RNs and LPNs who work in the nursing area (Comment 306, Harris).

For some or all of the reasons discussed above, numerous witnesses were opposed to applying the rule to nursing homes (Durham, 3179; Harris, 4293-94; Comment 284, Ryan; Comment 155, IHA; Comment 155, IHA, affidavit of Miller; Comment 3, Jefferson Davis Nursing Home). Three witnesses would support a two-unit approach (Comment 22, Louisiana Nursing Home Assn.; Comment 27, Jefferson Manor Nursing Home; Comment

34, Lewisburg United Methodist Homes). Several commentators thought the Board lacked sufficient experience with respect to nursing homes to formulate a rule as to such facilities (IUOE Br. 2, fn 1; Durham, 3179; Harris, 4304). Board statistics show that only 20% of the elections in the health care industry have involved long-term care facilities (Harris, 4302). Also, case-by-case determinations of appropriate units in nursing homes have not caused undue litigation (Comment 155, IHA). In fact, to the best of our knowledge there is not a single published case since the health care amendments in which the Board had to decide appropriate units in nursing homes, and no party testified that it had experienced problems with case-by-case determinations as to this issue.

In view of the evidence set forth above, we have decided to exclude nursing homes from the rule. The evidence shows that there are not only substantial differences between nursing homes and hospitals but also significant differences between the various types of nursing homes which affect staffing patterns and duties. In the absence of a measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units. It also appears that there is no need at this time for a rule with respect to nursing homes as there has been no prolonged litigation and no party has expressed any problems in this area. We, therefore, conclude that it is best to continue a case-by-case approach with respect to nursing homes. For those facilities which provide both hospital and nursing home services, if the facility is primarily an acute care hospital, it will be treated in its entirety as a hospital; if primarily a nursing home, it will be considered a home, and outside

the rule. To do otherwise would further fractionalize bargaining within the facility, and cause more, rather than less, proliferation.

XIV. Specialized Hospitals

Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes (Comment 172, New England Sinai Hospital; King, 4230-31). The evidence with regard to most of the specialty hospitals which participated in the rulemaking did not support a conclusion that there are fewer traditional distinctions between employee groups. However, the evidence demonstrated that psychiatric hospitals, are, for a number of reasons, in a category apart, and the Board has decided to exclude psychiatric hospitals from application of the rule.

Initially, the industry's claimed trend toward one-specialty hospitals is not supported by statistics. The AHA classifies 90% of U.S. private, acute care hospitals as general; of these, 98% are general medical and surgical hospitals and only 2% are pediatric or rehabilitation hospitals. Nine of the remaining ten percent are psychiatric, a category apart (AFL Exh. 7,8.) In California, where the industry contends the trend is particularly strong (Dauner, 3206), there are relatively few specialized hospitals (Silberman, 3209-12).

Most of the comments submitted to the Board from specialty hospitals apart from psychiatric hospitals did not argue that these hospitals should be treated differently from general acute care hospitals. See for example,

Comment 4, Le Bonheur Children's Medical Center, Comment 10, National Rehabilitation Hosp.; Comment 123, Children's Memorial Hosp.; and Comment 303, Children's Medical Center, Akron, regarding childrens' hospitals. Although Children's Medical Center of Dallas (Comment 276) states that in that hospital RNs integrate patient care with some other professionals, and Cardinal Glennon Children's Hospital (Comment 271) discusses use of the team approach, neither suggests that childrens' hospitals differ from general acute care hospitals for purposes of rulemaking. While Shriners Hospitals For Crippled Children (Comment 238) were unique in their method of obtaining funds and charging patients, they operate like other acute care hospitals, subscribing to the same rules of licensure and accreditation.

Two hospitals, Children's Hospital of Dayton and Children's Hospital of Cincinnati presented more details regarding the operation of childrens' hospitals (Testimony of Graybill, Sokatch; Comment 288, Graybill). There is evidence that childrens' hospitals have higher acuity and outpatient activities than general acute care hospitals, and as a result have more full time equivalent positions and higher budgets than comparably sized general acute care hospitals (Comment 288). There is also evidence that RNs have a somewhat higher level of interaction with other professionals, for example, interacting with respiratory therapists on ICU units and transports (Graybill, 4183), working on special teams like bone marrow transplants, interacting with pharmacists regarding allergies, and tube sequencing (Comment 288). Even assuming that respiratory therapists are professionals, a status the Board has rejected on some occasions, (see for

example, *Samaritan Health Services*, 238 NLRB 629, 638 (1978)), the interaction of RNs with other professionals, including presence on teams, is similar to that shown in other hospitals, and RNs' duties were not shown to be different merely because they may work on teams. As in other acute care hospitals, most nurses in childrens' hospitals are directly or indirectly supervised by other nurses (Graybill, 4147-48, 4164).

Comments from rehabilitation hospitals show similar arguments to those made by general acute care hospitals: that there is increased contact between RNs and other professionals, that there is some cross-training and utilization, that teams are used, that a hospital has across-the-board personnel policies (Comment 172, New England Sinai Hospital; Comment 131, The Institute for Rehabilitation and Research). These commentators did not request special treatment for their hospitals. Of course, to the extent rehabilitation hospitals may be long term, they will not fall within the parameters of the Board's rule, *infra*, which applies only to hospitals whose average patient stay is less than 30 days.

Nor was there a suggestion made by commentators of other, non-psychiatric, single specialty hospitals that their type of hospital merited special rules. For example, the Board received evidence from Springfield General Hospital (Comment 201) and Oklahoma Osteopathic Hospital (Comment 300), both osteopathic hospitals, in opposition to the rulemaking, but not claiming a special status for specialty hospitals.

As noted above, the evidence received on psychiatric hospitals supports an exception for this specialty. Psychiatric hospitals constitute a substantial portion (9%) of

private hospitals in the U.S. (AFL Exh. 7). Even the AFL, the only union which took a position on psychiatric hospitals, provided a mixed case for including these hospitals under the rule. Thus, while the AFL argued that psychiatric hospitals which provide short term care are acute care hospitals, it recognized that there is evidence to suggest that at least some professionals play different roles in psychiatric hospitals than in acute care hospitals (citing Albanese/Caswell, Chi I 148-165). Further, the AFL noted that the Board has treated psychiatric facilities differently from other hospitals. Thus, *Mt. Airy Psychiatric Center*, 253 NLRB 1003 (1981), was the only pre *St. Francis II* case in which the Board refused to find appropriate a separate RN unit. Finally, even the AFL acknowledged that the Board might wish to exclude exclusively psychiatric facilities from the rule. (AFL Br. 140, fn.).

The two main industry representatives who presented evidence on psychiatric hospitals strongly urged that psychiatric hospitals not be considered acute care hospitals for purposes of rulemaking. Most of the evidence submitted with regard to psychiatric hospitals came from the National Association of Private Psychiatric Hospitals (Comment 307, Thomas) and from Charter Medical Corporation (Albanese/Caswell, Chi I 148-165). The National Association represents a substantial majority of private psychiatric hospitals in the U.S. Charter Medical represents about 60 psychiatric hospitals. Therefore, the Board considers their evidence to be representative of psychiatric hospitals in general. The other employers representing psychiatric hospitals agree that psychiatric hospitals operate in a distinct manner (Comment 110, Charter Lakeside Hosp.; Comment 35,

Massachusetts Chapter of the National Association; Comment 29, Glen Eden Hospital; Comment 120, HCA Belle Park Hospital; Comment 168, Camelback Hospitals; Comment 298, Palo Verde Hospital).

The evidence showed that unlike other acute care hospitals, psychiatric hospitals do not provide patient care for the physically ill. RNs are not the primary facilitators of health care in psychiatric hospitals. Many professionals participate hands-on with patients. Regardless of which of three basic models a psychiatric hospital follows: medical, milieu, or combined, the programs are highly integrated. RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators.

There are more professionals other than doctors and RNs in psychiatric facilities than in other acute care facilities. The ratio of RNs to other professionals is about 1:1 regardless of facility size. It appears that non-RN professionals would not have the same concerns about being outnumbered in an all-professional unit as they have expressed regarding organization in acute care hospitals.

Psychiatric hospitals also differ from other acute care hospitals in that there are more paraprofessionals (mental health workers), and all employees are specially trained in relating to the patients as all employees' actions have an impact on patient treatment.

Further, the evidence shows that Congress has distinguished between acute care general and psychiatric hospitals under Medicare by setting special Medicare

certification requirements with respect to staffing, treatment planning, teams, etc.

For all these reasons, the Board has decided to exclude "primarily" psychiatric hospitals from its rule for units in acute care hospitals and to proceed as to them on a case-by-case basis. A number of acute care hospitals have psychiatric sections, however, and such hospitals are not thereby excluded from application of the rule unless the psychiatric sections predominate. Nor do we adopt the suggestion of the AFL that the exclusion be limited to hospitals that are "exclusively" psychiatric, as we deem such an exclusion to be too limited. See the definition of "psychiatric hospital" contained in 42 U.S.C. 1395 x (f).

XV. Partially Organized Facilities

In the first Notice of Proposed Rulemaking, we limited the applicability of the rule to petitions for initial organization, and commented that "historically the Board has required decertification petitions to be filed in the certified or recognized unit." (52 FR at 25145). By way of further explanation, the Board added that "when institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible." (*Id.*)

As indicated *infra*, in Sec. XIX, Combined Units, the principle of *Cambell Soup Co.*, 111 NLRB 234 (1955), will continue to apply to decertification petitions. See also *Westinghouse Electric Corp.*, 115 NLRB 530 (1956). With respect to other types of petitions in partially organized facilities, we wish to amplify our previous remarks.

In the Second Notice of Proposed Rulemaking, "insofar as practicable" language [changed from "insofar as possible"] is now part of the proposed rule. However, there are two different possible situations we can envisage:

(1) Where existing units are in conformity with the new proposed final rule, we can foresee no reason that new petitions, for the same or other units, should not also be in conformity with the new rule.

(2) Where existing units are not in conformity with the new proposed final rule, we can anticipate a number of questions arising with respect to the applicability of the new rules. Where units smaller than those permitted by the rules already exist, may the incumbent petition for a residual unit? May another labor organization? What will be the continued viability of the principles enunciated in *Levine Hospital of Hayward*, 219 NLRB 327 (1975)? In Comment 304, Kaiser Permanente raised a number of these questions, claiming that "many health care employers, including Kaiser Permanente, currently have bargaining relationships with unions in units that are narrower than those set forth in the proposed rules." These issues have not been extensively addressed during the rulemaking proceeding, and it is the Board's judgment that their resolution should, for the time being, be deferred pending the adjudication of particular cases that present these issues. The Board will, in the adjudication of cases, attempt to apply the new rules to these situations insofar as practicable.

XVI. Facilities Covered

The Board stated in its proposed rule that the rule would apply to acute care hospitals, but did not define the term. Noting the concern of some commentators during the Board hearings with the absence of a specific definition, the Board has carefully reviewed a variety of sources in order to reach a definition. In particular, the Board has extensively searched Federal health care legislation, agency regulations, legislative history, industry reference materials, and hearing testimony for an authoritatively based and commonly understood distinction suitable to the goals of rulemaking in the health care industry. Research reveals that there is a commonly understood distinction between acute and long term care facilities, but that the terms are not statutorily defined as such.

The Public Health Service, for example, draws a distinction between acute care and long term care facilities for the purpose of administering special projects and grants (42 U.S.C.S. 296k(a) (4) and (7) (1985)), and for administering grants to nurse practitioners and midwife programs (42 U.S.C.S. 296m(a)(2)(A) (1985)). Various sections of the Social Security Act make the same distinction: e.g., for purposes of determining the scope of review of peer group organizations (42 U.S.C.S. 1320c-3(a)(4)(A) (1986)), and for determining the application of payment in accordance with state reimbursement control systems (42 U.S.C.S. 1395ww(c)(1)(A) (1983)). Despite the repeated use of the terms acute care and long term care, however, no statutory definition is provided.

In regulations promulgated by the Department of Health and Human Services, the agency principally responsible for administering health care legislation, there is also a distinction between acute and non-acute care facilities. The term "like [similar] hospital", for example, is used in reference to the special treatment given sole community hospitals and is defined as a "hospital furnishing short-term, acute care." (42 CFR 412.92(c)(2) (1987)).

Finally, a review of the extensive legislative proceedings surrounding health care legislation and related issues likewise reveals regular use of the acute care/long term care distinction, with the terms "short term hospital" and "acute care hospital" used interchangeably. Here again, though, the use of these terms is so commonplace that no specific definition is provided.

In light of this commonplace usage, but lack of statutory or legislative definition, the Board has adopted the definition of an "acute care hospital" provided by the Dictionary of Health Services Management, edited by Thomas Timmreck, Ph.D., 1982, National Health Publishing, Owings Mills, Maryland.

The Dictionary of Health Services Management defines an "acute care hospital" as a short term care hospital with an average length of patient stay of less than 30 days. This definition was also referred to with apparent approval by the AFL in this proceeding and is used by the American Hospital Association (AFL Exh. 20, AHA Guide to the Health Care Field, 1987).

The definition of a "psychiatric hospital" for the purposes of this rule shall be that set forth in 42 U.S.C.

1395x(f). According to that definition, a psychiatric hospital is an institution which:

(1) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) Satisfies the requirements of paragraphs (3) through (9) in the definition of a "hospital" in that statute [§ 1395x(e)];

(3) Maintains clinical records on all patients; and

(4) Meets certain staffing requirements found necessary by the Secretary.

Coverage for the purpose of this rule, then, will include all acute care hospitals as defined. A hospital is covered if its primary service is acute care, regardless of the presence of other non-acute care units at the same facility. Psychiatric hospitals, defined above and dealt with in section XIV, are specifically excluded from coverage. Also excluded are nursing homes.

As previously indicated, rehabilitation and drug-alcohol hospitals that meet the 30-day standard are tentatively included as the Board did not receive sufficient information during the proceedings to distinguish these facilities for the purposes of this rulemaking.

XVII. Decisions To Which Rule Applies

The NPR suggested that the Board's new health care rule would be effective "on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule)." In *St. Vincent Hospital and Health Center*,

285 NLRB No. 64 (Aug 19, 1987), the Board indicated that while its proposed rulemaking procedure was pending, it would continue to make unit determinations in health care cases on a case-by-case basis utilizing the criteria set forth in *St. Francis Hospital*, 271 NLRB 948 (1984) ("*St. Francis II*"). The Board also reiterated that it would apply its new rule prospectively only to cases in which petitions were filed after the rule became effective. Based on comments received in the record, and upon further consideration, the Board has concluded that its rule regarding appropriate units in the health care industry shall apply to all decisions made on and after the effective date of the rule.

Representatives of unions urged the Board to revise the proposed prospective application of the new rule. One union suggested that the rule should be effective for all cases decided after the rule was published, even if the petition was filed prior to that date (ANA Br. 197). Unions suggested that it would be unsound, if not arbitrary, to disregard the rule in pending cases, considering the vast body of knowledge the Board now possessed by virtue of its rulemaking proceedings (ANA Br. 196, AFL Br. 145-146). The AFL asserted that to apply preexisting law would deny employees the right of self organization. The AFL noted that applying the rule retroactively would not have an ill effect on pending representation cases. The AFL also noted that the Board recently gave retroactive application to its decision in *John Deklewa & Sons*, 282 NLRB No 184 (Feb. 20, 1987), *enfd. sub nom Iron Workers Local 3 v. NLRB*, 843 F.2d 770 (3d Cir. 1988). Further, the AHA and AFL noted that the Board applied its *St. Francis II* decision retroactively, and remanded many bargaining

unit cases to regional directors for further consideration. (AHA Br. 203-204; AFL Br. 145.) ANA also noted the incongruity that could result if the Board enacted a rule that conflicted with pre-rule standards, e.g., finding a unit inappropriate that previously was appropriate. (ANA Br. 204 at n.115.)

The Board has decided that its rule on appropriate bargaining units in the health care industry should be applied to all decisions made on and after the effective date of the rule, which will be 30 days after publication of the final rule in the Federal Register. See APA, 5 U.S.C. 553(d). The Board agrees that it would be incongruous to apply the rule as originally stated; that is, only to petitions filed 30 days after publication. Such a rule would arbitrarily affect petitions filed just 1 or 29 days after the rule is published, and could conceivably lead to vastly different results based solely on the timing of the petition. However, the Board will apply its pre-rule standards to cases that issue prior to the effective date of the rule. As we indicated in *St. Vincent*, we deem it unwise either to decline to take any action on pending petitions, or to promulgate a new standard while rulemaking proceedings are pending. We continue to deem it contrary to statutory policy to hold cases pending effectuation of the Board's new rule. Accordingly all cases that issue prior to the effective date of the rule will be analyzed under *St. Vincent*. If cases currently pending before the Board do not issue prior to the rule's effective date, the Board will not apply the rule *de novo* to such cases. Rather, the Board will, where necessary, remand such pending cases to regional directors to determine the need for a hearing or

other appropriate course of conduct in order to permit parties to address the rule.

XVIII. Non-Conforming Stipulations

In the initial proposed rule, the Board stated that it would approve consent agreements providing for elections in accordance with the units set forth in the rule, and that no other agreements would be approved. Several commentators urged the Board to permit stipulated units even when they do not comport with those specified in the rule. We have been persuaded that permitting non-conforming stipulations, which are not prohibited by the Act, may, in many instances, better serve the interests of the parties, and perhaps even the Board. The Board therefore has tentatively decided to allow its regional directors to approve stipulations providing for elections in units not provided for in the rules.

It is the Board's established practice in other areas to permit parties to stipulate to the appropriateness of units and to various inclusions and exclusions if the agreement does not violate any express statutory provision or established Board policies. See, e.g., *SCM Corporation*, 270 NLRB 885, 886 (1984). This policy on stipulated units was extended to the health care industry in *Otis Hospital*, 219 NLRB 164 (1975). The Board there reasoned that it is consonant with the design of the Act to give the parties in representation proceedings the broadest permissible latitude to mutually define the appropriate unit. The Board stated that when the parties' perceptions coincide regarding unit appropriateness, in the absence of a statutory command or policy considerations within the Board's

expertise, the Board is not the better judge. The Board noted in *Otis Hospital* that the legislative history of the 1974 health care amendments supports the application of general policy regarding stipulated units to the health care industry.

Our expertise acquired throughout this rulemaking proceeding gives us considerable pause with regard to stipulations not in accordance with our proposed rules. Thus, stipulations in conformity with these rules would surely be preferable. However, we recognize the possibility that the parties have their own reasons for preferring to bargain in some other configuration. Moreover, we note that the majority of certifications issued in representation cases in the health care industry following enactment of the amendments followed either a consent or stipulated election and that these elections gave rise to challenges less often than directed elections. Annual Reports of the National Labor Relations Board, Tables 9, 11B. In view of Congress' concern with stability in health care labor relations, the importance of reducing unnecessary litigation, and expeditiously proceeding with elections, permitting stipulations, even when they do not conform to the Board's explicitly drawn units, seems warranted. For these reasons, we have decided that the reasoning of *Otis Hospital* should remain applicable despite this rulemaking proceeding.

To the extent a stipulation may later result in the creation of a residual group of unrepresented employees, the Board will address their representation concerns as it would those of other groups of residual employees present in partially organized acute care hospitals – on a case-by-case basis applying the rules insofar as practicable.

Despite our tentative decision to accept non-conforming stipulations, we expressly invite any interested party to comment further on this problem during the period provided for comments.

XIX. Combined Units

The Notice of Proposed Rulemaking provided that, in addition to the specified units, "any combination will also be appropriate, at the union's option and so long as the requirements of section 9(b) (1) and (3) are met." The reason for the reference to the union's option was that the union, as petitioner,²⁶ need seek only an appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 417-18, enfd. on other grounds 190 F.2d 576 (7th Cir. 1951); *Parsons Investment Co.*, 152 NLRB 192, 193 at fn. 1 (1966). It does not benefit an employer to have the option of showing that another unit, perhaps a combined unit, is also appropriate, or even more appropriate, since the appropriateness of an alternative unit is not the issue. *Parsons Investment Company*, *supra*; *Federal Electric Corporation*, 157 NLRB 1130, 1131-32 (1966). We therefore reject arguments by some employers that it is unfair to give only unions the option of combining units. (See, e.g., AHA Br. 49; Comment 258, Durham, attorney for California Association of Health Facilities.)

²⁶ If the employer is the petitioner (RM petition), its petition must seek the unit requested by the union. *Wm. Wood Bakery*, 97 NLRB 122 (1951); *Restaurant & Tavern Owners Association of Salem*, 126 NLRB 671 (1960). If the petition seeks decertification, it must be filed in the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955).

However, upon reflection, we believe that we defined too broadly a union's option to seek, alternatively, combined units. In the NPR, as indicated, we implied that *any* combination of the enumerated units would also be appropriate; after giving this matter further thought, we believe that we have insufficient evidence at this time to say that, *per se*, all combinations will be found appropriate. We believe this is a matter we will have to decide in the course of individual cases, by adjudication. While there are some combinations that, while not required under these rules, would obviously be appropriate, such as all professionals, or all non-professionals, there may be other, more unusual combinations that need to be examined for appropriateness. We meant to say only that combinations of the enumerated units are not thereby precluded, and we have therefore modified the rule to provide that combinations "may" be appropriate.

XX. Extraordinary Circumstances Exception

The Board has, in order to ensure satisfaction of parties' due process rights,²⁷ included in both the proposed rule and the final rule an exception for "extraordinary circumstances." The exception has been provided to

²⁷ See *Chemical Manufacturers Assn. v. Natural Resources Defense Council*, 470 U.S. 116, 133 n. 25 (1985); *Heckler v. Campbell*, 461 U.S. 458, 467 (1962); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956); *National Broadcasting Company v. United States*, 319 U.S. 190, 225 (1943); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969); 1 C Koch, *Administrative Law and Practice* § 4.112 at 321-23 (1985).

allow for the possibility of individual treatment of uniquely situated acute care hospitals, so as to avoid accidental or unjust application of the rule.²⁸ However, the Board wishes to emphasize that while the rule does not, therefore, conclusively establish invariable parameters of bargaining units in the industry, our intent is to construe the extraordinary circumstances exception narrowly, so that it does not provide an excuse, opportunity, or "loophole" for redundant or unnecessary litigation and the concomitant delay that would ensue. The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions. The Board deems such variations to be ordinary, and hence by definition not extraordinary,²⁹ even in situations in which such variations may be highly unusual.³⁰

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are

²⁸ Cf. *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 784 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975), citing *The New England Divisions Case*, 261 U.S. 184, 204 (1923).

²⁹ See *Bollman v. Indianapolis Machinery Co.*, 150 Ind. App. 296, 276 N.E.2d 606, 613 (1971); *Black's Law Dictionary* 527 (rev. 5th ed. 1979), and cases cited therein.

³⁰ See *Kugler v. Helfant*, 421, U.S. 117, 125 (1975).

arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above,³¹ alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

The Board is well aware that facilities will, and do, differ in some respects; however, as we observed in the NPR (52 FR 25144), it is the Board's considered judgment, after issuing health care decisions by adjudication for

³¹ The arguments listed were selected by way of example and not by way of limitation, and were chosen merely as being illustrative of the Board's intent.

more than 13 years, that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units.³² Moreover, to the extent that the rulemaking hearings demonstrated that at least in some respects acute care hospitals do vary, the Board has made a judgment that, in this area of establishing appropriate units, "[d]etailed analyses of all the facts of the particular case are just not that enlightening,"³³ and that the policies of the Act would better be effectuated by the establishment of appropriate units in the enumerated segments of this industry by exercise of the Board's section 6 rulemaking authority.³⁴

To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding,"³⁵ as, for instance, by

³² See, e.g., NLRB Exhibit 5, revised, showing that for the 13 years since passage of the health care amendments, variations among facilities and their methods of operation had virtually no effect on the Board's ultimate decisions reached following frequently lengthy, case-by-case adjudications as to appropriate units.

³³ Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981).

³⁴ See *Cummins v. Schweiker*, 670 F.2d 81, 83 (7th Cir. 1982).

³⁵ *Basic Media, Ltd. v. FCC*, 559 F.2d 830, 834 (D.C. Cir. 1977). *Accord, P & R Temmer v. FCC*, 743 F.2d 919, 930 n.11 (D.C. Cir. 1964); *Industrial Broadcasting Co. v. FCC*, 437 F.2d 680, 683 (D.C. Cir. 1970). See also *WAIT Radio v. FCC*, 459 F.2d 1203, 1207 (D.C. Cir. 1972), cert. denied 409 U.S. 1027 (1972); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969).

showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust³⁶ or an abuse of discretion³⁷ for the Board to apply the rules to the facility involved.

The Board, contrary to some industry representatives (e.g., Comment 148 Mississippi Hosp. Assn.), anticipates that litigation under the "extraordinary circumstances" exception will be rare; the AHA, representing the largest group of health care employers in this proceeding, has indicated it understands that the Board intends to limit exceptions to "truly extraordinary situations" (AHA Br. 55-56), and neither the AHA nor any other employer (or union) representative has raised objections to the Board's stated intent.

In most instances, should a facility claim it comes within the "extraordinary circumstances" exception, it should present an offer of proof to the Hearing Officer, who will then either permit the requested evidence to be adduced or, we anticipate far more commonly,³⁸ refer the offer to the Regional Director, and, if requested, ultimately to the Board, for ruling.

³⁶ *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 763 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975).

³⁷ *P & R Temmer v. FCC*, 743 F.2d 919, 929 (D.C. Cir. 1984); *Ashland Exploration, Inc. v. FERC*, 631 F.2d 817, 823 (D.C. Cir. 1980).

³⁸ See 1 C. Koch. *Administrative Law and Practice* section 4.112 at 323 (1965).

XXI. Proliferation

As set forth in considerable detail, *supra*, the evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units (seven plus guards) should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation set forth in the legislative history of the 1974 health care amendments as well as its own strongly-held view that the number of units found appropriate should not be so many as to lead to a splintering of the workforce into the myriad of occupations and professions found within the industry. The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns. A number of groups of employees found appropriate have separate labor markets. A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

We believe that Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately. IUOE Br. 96-97: Legislative History of the Coverage of Non-Profit Hospitals

Under the National Labor Relations Act at 113-114 (Senator Taft); Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973 at 175 (David Brekke, Colorado Hospital Association), 181 (O. Ray Hurst, Texas Hospital Association), 188 (William Whelan California Hospital Association), Sidney Lewine, 138-139 (American Hospital Association), 563-564 (exchange between Senator Taft and Andrew Biemiller of the AFL-CIO). See also testimony in 1971 and 1972 hearings, cited in IUOE Br. 96-97.

By 1974, a number of state and agency decisions with respect to non-profit hospitals, and Board decisions with respect to proprietary hospitals, had permitted each profession, and in some cases each craft, to form a separate bargaining unit (See discussion in AFL Br. 2-3, 28). As stated in Senator Taft's proposal, Congress feared that patterns such as developed in construction and newspaper industries -wherein units were permitted for each craft, resulting in 15-20 or more units - would result in separate units for the equally, if not more, numerous classifications in a hospital. We find no evidence that Congress opposed a smaller number of units. Thus, Senator Taft's proposal, containing special rules for the health care industry, would have established five units as presumptively appropriate: Technical, clerical, service and maintenance, all professional, and guards, two more than the statutorily mandated three units (professional, non-professional, and guards). The Board's addition of three units, RNs, physicians, and skilled maintenance, raising the total number of proposed possible units to eight, still constitutes half or fewer of the number of units that seem to us to have concerned Congress.

Furthermore, the record shows that the hospital industry understood proliferation to mean a much greater multiplicity of units than is proposed here. The League of Voluntary Hospitals of New York, an association of 54 nonprofit medical centers, hospitals, and nursing homes, and the largest organization of its kind in the country, supported the 1974 amendments because the League wished to remove itself from New York State health care coverage under which there were potentially 15-20 or more units in a health care facility (WS Abelow). Indeed, the American Hospital Association proposed a five-unit configuration: Professional, technical, clerical, service and maintenance, and guards. Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973, Sidney Lewine, 140.

There is little evidence that the number of units proposed by the Board will result in proliferation or in the problems perceived to arise from proliferation. The units proposed by the Board are only potential units. Indeed, two of the units, physicians and guards, are rarely sought. A successful organizing effort in one unit in a hospital does not appear to have a ripple effect causing further organization. The record shows that from the 1974 health care amendments until the Board's 1984 decision in *St. Francis II*, most health care units fell into the categories now proposed by the Board. However, the majority of organized hospitals only had one unit, and about 80% had three or fewer units. (AFL Exh. 5 p. 1; SEIU, WS Shea, Table 2.) Nor, as detailed *supra*, was there a showing that the configuration of units proposed by the Board have resulted in an increased number of strikes,

jurisdictional disputes, or other disruptions in the delivery of health care services.

Finally, as shown above, the empirical evidence submitted in these proceedings strongly supports the appropriateness of each of the units proposed by the Board.

For all the above reasons, we conclude that our proposal for seven units plus guards is not only well within our discretion, but also consistent with both our own and Congress' concerns about proliferation.

XXII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so they can participate effectively in the rulemaking process; and (2) to serve as the record in case of judicial review. As provided in the first NPR (52 FR 25148), the docket, including a verbatim transcript of the hearings, the exhibits, the written statements, and all comments submitted to the Board, is available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, D.C.

XXIII. Regulatory Flexibility Act

As required by the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the Board certifies that the proposed rule will not have a significant economic impact on small entities. Prior to this rule, parties before the Board were

required to litigate the appropriateness of a unit for election purposes if they could not reach agreement on the issue. Upon enactment of this rule, parties will no longer be required to engage in litigation to determine the appropriateness of units, thereby saving all parties the expense of litigation before the Board and the courts. To the extent that organization of employees for the purpose of collective bargaining will be fostered by this rule, thereby requiring small entities to bargain with unions, and that employees may thereby exercise rights under the National Labor Relations Act, as amended (29 U.S.C. 151 *et seq.*), the Board notes that such was and is Congress' purpose in enacting the Act and the health care amendments thereto.

XXIV. Regulatory Text

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the prior pages, it is proposed to amend 29 CFR Part 103 as follows:

Part 103 - OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 151, 156; 5 U.S.C. 500, 533.

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C - Appropriate Bargaining Units

Sec.

103.30 Appropriate bargaining units in the health care industry.

Subpart C - Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that various combinations of units may also be appropriate:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.

(8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

(b) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate units set forth in paragraphs (a) (1) through (8) of this rule.

(c) Nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after the effective date of the final rule.

(f) For purposes of this rule, the term "acute care hospital" is defined as a short term care hospital in which the average length of patient stay is less than thirty days. The term "acute care hospital" shall include those hospitals primarily operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, or psychiatric care, but shall exclude facilities that are primarily nursing homes

or primarily psychiatric hospitals. The definition of "psychiatric hospital" shall be as set forth in 42 U.S.C. Sec. 1395 x (f), Social Security Act. A "non-conforming unit" shall be defined as a unit not in conformity with paragraphs (a) (1) through (8) of this rule.

(g) Appropriate units in all other health care facilities: The Board will establish appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, on a case-by-case basis.

XXV. Dissenting Opinion

Member Wilford W. Johansen, dissenting:

As amply documented in the Notice of Proposed Rulemaking in the Federal Register on July 2, 1987, there has been no universal acceptance in the circuit courts of a standard for formulating appropriate units in the health-care industry. Some courts have simply substituted their own judgment for that of the Board on the question of what constitutes an appropriate unit. Frequently a court has apparently supported its conclusion by a selective reading of portions of the legislative history of the 1974 Amendments. The Board in turn has reacted first by trying to explicate that the differences might be "largely semantic" (*Newton-Wellesley Hospital*, 250 NLRB 409 (1980)), then by reversing field and adopting the test advocated by the Ninth Circuit (*St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*)). That course in turn was roundly criticized by the D.C. Circuit. (*Electrical Workers IBEW Local 474 v. NLRB (St. Francis Hospital)*, 814 F.2d 697

(1987)). The Board's reaction was to try yet a different approach - i.e., rulemaking.

With all due respect, I disagree. Rulemaking in regard to healthcare units is neither desirable nor appropriate.

First, it is my view that the appropriate method for resolution of questions surrounding the interpretation of Congress' intent, the proper scope of review, and the Board's duty and authority under the statute, is to submit these questions to the Supreme Court, which is the final arbiter on issues of this nature. Submission to the Court is especially appropriate in this area. Second, the Board has received criticism from the courts at both ends of the spectrum. Most of the criticism and disagreement has centered around application of the traditional community of interest standard, versus a separately derived "disparity of interest" test for evaluating units in the health-care industry.

Thus, the Ninth Circuit, in an early *St. Francis* hospital case, faulted the Board for applying what the court deemed a too rigid presumption *in favor* of a registered nurses unit; and enunciated a "disparity of interest" standard, which it deemed necessary for assessing healthcare units. More recently, after the Board itself decided to adopt the disparity of interest standard, the District of Columbia Circuit in yet another *St. Francis* case, severely criticized the Board's action, and strongly "suggested", that some form of the historically accepted community of interest standard is required. Hence the Board is faced with some courts which have indicated a definite preference for the so-called "disparity of interest" analysis.

Other courts are equally adamant that nothing in the 1974 Amendments indicates that the Board was to abandon the community of interest standard which had served well for the previous forty years, and of which Congress was cognizant at the time of the Amendments.

It is apparent that the disagreements involve questions concerning the meaning of the statute, analysis of the legislative history, and the deference to be properly accorded to the Board's reading and interpretation of the Act, which is the Board's primary function and responsibility. These questions are all particularly appropriate for submission to, and final resolution by, the Supreme Court. This avenue is also the one which best serves the interests of the parties, the general public, and the Board itself.

Section 9(b) of the Act provides that

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . .

I do not read the above language as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking per se. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to keep in mind that Congress did *not* amend Section

9 when it enacted the Healthcare amendments in 1974. Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action. The rule changes cited by the majority (e.g., contract bar, *Excelsior* list, etc.) in support of this radical departure from 50 years of Board precedent, (a) were arrived at decisionally, and; (b) did not involve unit determinations.

There are additional factors which make rulemaking on particular units, at best, inadvisable. Units established by rulemaking will continue to be criticized by courts that deem the Board's approach to healthcare unit determinations to be too rigid. Indeed, as unit specifications derived from a predetermined set of rules are inherently less flexible than those arrived at by decision in individual cases, criticism by some courts may even intensify on the ground that the Board has not arrived at a result through the application of its institutional expertise to a particular fact pattern.

Contrary to the stated expectations of my colleagues, setting unit configurations by rulemaking will not in fact substantially reduce the amount of litigation in this area. It may serve to change part of the focus of that litigation, while at the same time creating more. The amount of evidence produced in rulemaking is not the point. The difficulties encountered over the last several years have not been for lack of evidence. Rather, they have revolved around differing interpretations of the statute and, particularly, the legislative history and the deference to be accorded the Board and its expertise in its role as the

primary decision maker under the Act. I do not see that announcing rules by administrative fiat will resolve the divergent views on these fundamental questions. We still will not have obtained a definitive resolution of the basic issues which is so sorely needed.

I would, therefore, vacate the notices of proposed rulemaking and submit the extant issues to the Supreme Court for resolution.

Dated, Washington, DC, August 25, 1988.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 88-19688 Filed 8-31-88; 8:45 am]

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NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board

ACTION: Final rule.

SUMMARY: The Board issues a Final Rule providing for appropriate bargaining units in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

EFFECTIVE DATE: May 22, 1989.

FOR FURTHER INFORMATION CONTACT: John C. Truesdale, Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

SUPPLEMENTARY INFORMATION: The following is an outline of the contents of this Supplementary Information:

- I. Background
- II. Rulemaking
- III. Cost Considerations
- IV. Employer Flexibility
- V. Common Expiration Dates
- VI. The Units
- VII. Small Units
- VIII. Equal Employment Considerations
- IX. Coverage of the Rule

- X. Miscellaneous Problems
- XI. Placement Decisions
- XII. Extraordinary Circumstances
- XIII. Proliferation
- XIV. Regulatory Flexibility Act
- XV. Dissenting Opinion

I. Background

On September 1, 1988, the Board issued its Second Notice of Proposed Rulemaking (NPR II) (53 FR 33900), modifying in some respects the rule tentatively proposed in its original Notice of Proposed Rulemaking (NPR) (52 FR 25142). Member Wilford W. Johansen dissented from the Board's decision to proceed with rulemaking. For reasons set forth in NPR II (53 FR 33901), the Board provided for another period of comment on all aspects of the proposed rule; that period ended October 17, 1988.

During this additional comment period, the Board received approximately 1500 timely comments. A number of comments received through Congressional offices were copies of letters also sent directly to the Board. On March 23, 1989, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry, and this Final Rule is the product of that open meeting. The Board is appreciative of the extensive interest shown by all segments of the health care industry during this rulemaking proceeding, and has carefully considered the entire record during its deliberations. Though this Supplementary Information contains references to various comments submitted during this final phase, the Board wishes to emphasize now, as it did earlier (53 FR 33901), that these references are merely

illustrative. The Board's decision has been based on the complete rulemaking record, including the transcript, the witnesses' statements, all comments and briefs, and the exhibits, and not solely on the testimony and comments referred to in NPR, NPR II, and this Supplementary Information.

Approximately 30 of the comments submitted during this final comment period support the Board's proposal in whole or in part, and approximately 1465 comments oppose it. Of the 1465 comments in opposition, approximately one-half are form letters, for the most part containing brief arguments without supporting detail.

The most common form letter, submitted by over 600 correspondents, briefly exhorts the Board to return to the case-by-case approach and to find appropriate only two units, all professionals and all nonprofessionals, plus the statutorily-mandated separate unit of guards. Otherwise, say these commenters, their ability to provide comprehensive, coordinated care would be adversely affected. An example of this form letter is that submitted by St. Luke's Hospital in Bethlehem, Pennsylvania (Comment 434). The form letter contains blank spaces for such information as "(name of organization)"; "(number)" of health care facilities owned by the commenter; and "(number)" of employees; one submitted copy of the form letter did not have the blanks filled in.

A second form letter, such as that submitted by St. Mary's Health Center of St. Louis, Missouri (Comment 875), has been received from approximately 35 commenters, and contains only four sentences. This letter also asks the Board to abandon rulemaking and return to a

case-by-case analysis, arguing that, in ways not specified, the rule will increase the risk of life-threatening strikes and result in jurisdictional disputes, inefficient work rules, and higher consumer costs.

The other two most frequently submitted form letters are those received from the Humana chain and its affiliates; over 35 copies of these two form letters have been received. Illustrative of one type is that received from Humana Hospital-Winn Parish (Comment 1474). This letter argues that the proposed rule fails to consider the differences in hospitals and specific circumstances of employees at a time of dynamic change in the industry, could limit flexibility in dealing with personnel at a time this flexibility is needed, and will result in increased costs at a time of growing demand for cost containment. This letter urges the Board to continue a case-by-case analysis, arguing that the rule contravenes Congressional intent.

The other Humana form letter was that submitted by Steven L. Durbin, Vice President of Employee Relations/Education, Humana Inc. (Comment 905), which makes similar arguments but also gives various examples of duties nurses now undertake (e.g., as in service education, utilization review and discharge planning, or admissions), to show changes in the industry. The letter adds that two proposed units, skilled maintenance and other professionals, would be very small units. The letter argues that the Board's rationale in its proposed rule has inconsistencies regarding salaries of nurses and uniformity in the industry. The letter further argues that the Board is abandoning *St. Francis II* (*St. Francis Hospital*, 271 NLRB 948 (1984)) to save time and resources for itself and

suggests other mechanisms for dealing with these problems.

Of the remaining one-half of the comments which oppose the proposed rule, the vast majority make general arguments with little, if any, supporting detail, and many contain portions of the form letters. The arguments in these comments, which for the most part mirror those made during the earlier portions of the rulemaking proceeding, generally fall within the following categories:

- a. The health care industry is unfairly being singled out for rulemaking.
- b. Rulemaking is contrary to the language of section 9(b), requiring a case-by-case approach.
- c. The Board should follow the case-by-case approach of *St. Francis II*.
- d. The number of proposed units conflicts with the Congressional admonition against proliferation.
- e. If the Board establishes units, there should be only two units, professional and nonprofessional, plus guards.
- f. The proposal will lead to increased organizing by unions.
- g. Multiple units will result in strikes, repeated strike notices, jurisdictional disputes, and other disruptions of health care.
- h. Health care costs will substantially increase as a result of strikes, whipsawing, work rules, bargaining, and contract administration.

i. Hospitals will lose needed flexibility.

j. The Board did not consider the changes in the industry such as teams, and the differences between institutions and between employees.

k. The particular units proposed, such as RN and skilled maintenance, are inappropriate.

l. The implementation of the proposed rule will lead to increased litigation.

m. At least 75 commenters argue that the Board should not treat small, rural hospitals as it does other acute care hospitals because they have less money and staff flexibility, and more overlapping employee duties. Moreover, disruptions at these facilities would have a severe impact on providing health care and employment for persons living in their areas since there are few or no other medical facilities nearby. Many of the 75 commenters provide no further detail on this point.

n. Several commenters embrace the arguments made by Member Johansen in his dissent from the Board's decision to continue with rulemaking.

o. Some commenters argue that the Board is inappropriately foreclosing discussion on bargaining unit issues by refusing to hear evidence on issues considered during rulemaking.

p. About 25 commenters argue that no rule should be made with less than a full five-member Board.

q. Some commenters suggest that the Board consider alternative to a rule, such as a Board panel deciding health care cases.

r. A few commenters argue that the implementation of the Board's proposed rule will expedite the Board's election process resulting in insufficient time for an employer to respond to a union's organizing campaign.

s. Some comments criticize the extraordinary circumstances provision as being too narrow.

The Board has carefully considered all the above arguments. Some (a, c, e, f, g, j, k, l, and n) were thoroughly dealt with in NPR and NPR II, and the Board believes that no further consideration or response is required. As to these arguments, the Board reaffirms the Supplementary Information and rationale contained in NPR II, as well as pertinent parts of the original NPR.

The point made by the 25 commenters referred to in "p" is moot, since all five Board Members have participated in the consideration and promulgation of this Final Rule.

With respect to the point made in "r," it is the Board's expectation that the rule will reduce what has hitherto been excessive delay and uncertainty in determining the appropriate bargaining unit, but otherwise all the Board's normal processes remain.

With respect to the remaining arguments: argument "b" is considered at II; "d" at XIII; "h" at III; "i" at IV; "m" at VII; "o" at II and XII; "q" at II; and "s" at XII.

The Board acknowledges and has taken into consideration the numerical superiority of the comments opposing the rule proposed in NPR II. From the beginning of this proceeding, employers have preferred continued use

of the adjudicatory approach,¹ and labor organizations have favored rulemaking. Since there are many more hospitals than unions in the health care industry, the disparity in the number of comments is not surprising. Although there are exceptions, the comments are for the most part divided pro and con along employer-union lines.

We do not view our task as similar to that of a scale-master, weighing the total body of comments for quantity without regard to substance. Insofar as we have found particular comments to be persuasive, we have reflected that in revisions to the rules previously proposed. To the extent we have found comments to be unpersuasive, we have so indicated in these and previous Supplementary

¹ The Board in NPR II at 33229 stated, in the introduction to Section XIV on Specialized Hospitals, "Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes * * *." Attorney Roger King, among others, was cited, TR 4230-31. In Comment 1142, Bricker & Eckler correctly points out that King's argument at the cited pages was that today's hospitals are varied and complex, and that rulemaking is "not suited for those institutions." The commenter is correct: throughout these proceedings, King has opposed rulemaking in every form, for all institutions. However, the Board intended at the point in question merely to introduce the discussion as to whether specialty hospitals should be covered by the rule; reference to a separate rule for such hospitals was inadvertent, and that possibility was not considered by the Board in NPR II. In fact, the Board excluded psychiatric hospitals from the proposed rule, it did not make a separate rule for them. The misstatement about King's testimony as to this point was immaterial to the Board's deliberations but is hereby acknowledged and corrected.

Information sections. The Board "is not required to mold its decision to accord with the weight of the comments it receives." *M.C.I. Telecommunications Corp. v. FCC*, 675 F.2d 408, 415, n. 39 (D.C. Cir. 1982), cited with approval in *Telocator Network of America v. FCC*, 691 F.2d 525, at 538 (D.C. Cir. 1985). Cf. *Lloyd Noland Hospital & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985).

II. Rulemaking

In both prior Notices, the Board set forth at considerable length the reasons prompting it to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25143 through 25145, and 53 FR 33901 through 33904, and are still valid.

Both the AFL-CIO (AFL) in its brief filed jointly with eleven other labor organizations (Comment 1713), and the American Hospital Association (AHA) in its brief (Comment 1711), deal at length with the Board's authority under section 9(b) to engage in rulemaking in the area of appropriate bargaining units. See also Comment 1055, Eastern Hospital; Comment 1330, Taft, Stettinius & Hollister; Comment 1663, Labor Policy Association; and Comment 379, James T. O'Reilly (supporting), among others.

Section 9(b) of the National Labor Relations Act requires the Board to decide "in each case" what the appropriate bargaining unit shall be. At the same time, section 6 gives the Board general authority to make rules, in the manner set forth in the Administrative Procedure

Act, "as may be necessary to carry out the provisions of this Act."

We have carefully examined the legislative history of these sections, particularly that surrounding section 9(b), and find nothing to impugn the legitimacy of this rulemaking proceeding. The words "in each case" were added to S. 1958 by Secretary of Labor Perkins, along with a number of other changes, as "small amendments" to be "made for the sake of clarity." I Legislative History (1935) at 1442 (Hearing 3/12/35.) A later House version of the bill, HR 7978 (5/9/35), contained the "in each case" language (II Legislative History at 2903), although earlier House bills had not. The House Committee Report, submitted by Representative Connery, stated:

Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit, employer unit, or other unit. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination. There is a similar provision in the Railway Labor Act of 1934 (sec. 2(9); 2(4)). (II Legislative History, *supra*, at 2976.)

The AFL suggests that the National Mediation Board (NMB), which administers section 2(9) of the Railway Labor Act, has defined units in the airline industry on an industry-wide basis as the result of industry-wide proceedings. If that were so, it would seem clear, consistent with Congressman Connery's analogy, that the Board could decide units for an entire industry also. However,

the cases cited by the AFL in its comment (p. 12, n. 18), are not fully supportive of its position. Though the NMB has used industry-wide proceedings for bargaining unit determinations in the airline industry, its pronouncements in each of the six proceedings that have been called to our attention have been limited to the particular airline involved.

For the reasons set forth in the NPR and NPR II, including the virtually unanimous views of courts, scholars such as Kenneth Culp Davis, and many other experts, we believe that our use of our rulemaking authority in this area is well within our discretion. In addition to the reasons previously given, we note that the Board has long made use of "rules" of general applicability to determine appropriate units, for example: (1) That single facility units are presumptively appropriate. *Haag Drug Company, Inc.*, 169 NLRB 877 (1968). See also *NLRB v. New Enterprise Stone & Lime Co.*, 413 F.2d 117 (3d Cir. 1969); (2) that residual units are not separately appropriate when sought by an incumbent. *The Budd Co.*, 154 NLRB 421 (1965); (3) that plant clericals and office clericals do not constitute an appropriate unit absent agreement of the parties. *The Kroger Co.*, 204 NLRB 1055 (1973); *Robbin & Myers, Inc.*, 144 NLRB 295 (1963); (4) that the appropriate unit in decertification elections is the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955). See also the "rules" described in *Otis Hospital*, 219 NLRB 164, 166 (1975), pertaining to the appropriateness of residual units in the health care industry.

We are aware of no judicial criticism of the Board's longstanding use of "rules" in the appropriate bargaining unit area, and the Supreme Court in *NLRB v. Wyman-*

Gordon Co., 394 U.S. 759 (1969), strongly suggested that, when it promulgated "rules," the Board would be better advised to utilize its rulemaking powers under the Administrative Procedure Act (APA). The Supreme Court similarly endorsed the Board's use of its rulemaking powers in *NLRB v. Metropolitan Life Insurance Company*, 380 U.S. 438 (1965), at 444, n. 6, when, in remanding a bargaining unit case to the Board, the Court stated:

Of course, the Board may articulate the basis of its order by reference to other decisions or its general policies laid down in its rules and its annual reports, reflecting its "cumulative experience," so long as the basis of the Board's action, in whatever manner the Board chooses to formulate it, meets the criteria for judicial review. (Citations omitted.)

There is nothing inconsistent between section 9(b) and the Board's use of its APA rulemaking power. Section 9(b) requires the Board to decide the appropriate unit in each case, and the Board will continue to do so under this rule. Should the parties not agree on the appropriate unit, a hearing in each case will still be directed, with the Board ultimately rendering a decision on the appropriate unit applicable to that particular petition and that particular employer's operation. The Board may rely on a rule properly promulgated under the APA just as it has, since 1935, relied on rules formulated under adjudication. The Supreme Court said as much in a recent case arising under the Social Security Act. That Act, like the NLRA, requires determinations (of disability) to be made on an individual basis, after hearings, if the issue is in dispute. Because of similarities between cases, the Secretary of Health and Human Services promulgated, through

rulemaking, a grid or matrix, through which it could be determined, with considerable predictability and uniformity, whether disability in a particular case existed. In *Heckler v. Campbell*, 461 U.S. 458, 467 (1983), the Court stated:

We do not think that the Secretary's reliance on medical-vocational guideline is inconsistent with the Social Security Act. It is true that the statutory scheme contemplates that disability hearings will be individualized determinations based on evidence adduced at a hearing. See 42 U.S.C. sec. 423(d)(2)(A) (specifying consideration of each individual's condition); 42 U.S.C. sec. 405(b) (1976 ed., Supp. V) (disability determination to be based on evidence adduced at hearing). But this does not bar the Secretary from relying on rulemaking to resolve certain classes of issues. The court has recognized that even where an agency's enabling statute expressly requires it to hold a hearing, the agency may rely on its rulemaking authority to determine issues that do not require case-by-case consideration. See *FPC v. Texaco Inc.*, 377 U.S. 33, 41-44 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). A contrary holding would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding. See *FPC v. Texaco Inc.*, *supra*, at 44.²

² In *Heckler*, the Court noted that, at the statutorily-required "hearing," the claimants would be given "ample opportunity both to present evidence relating to their own abilities and to offer evidence that the guidelines do not apply to them (footnote omitted)." (*Id.* at 467.) Similarly, here, if the parties do not execute one of the Board's stipulated or consent

(Continued on following page)

As indicated, some of the form letters, as well as Comment 884a, submitted by Martha Jefferson Hospital, Comment 1049 submitted by Vanderbilt University School of Nursing, and Comment 905, by Humana Inc., suggest as an alternative that the Board establish special panels "in the Regions and Washington to hear, decide and resolve health care bargaining unit issues." This is

(Continued from previous page)

agreement forms, and the petition is not dismissed for administrative reasons, there will be the hearing required by section 9(c) of the Act. At the hearing, the facility being organized, or the union, will be given ample opportunity to demonstrate that the unit guidelines are not applicable to it for such reasons as (a) the facility is not a hospital; (b) insufficient numbers of its patients receive acute care; (c) it is primarily a nursing home; (d) it is primarily a psychiatric hospital; (e) it is primarily a rehabilitation hospital; (f) its situation presents "extraordinary circumstances"; etc.

Moreover, we note that, under section 9(c) of the NLRA, the "hearing" requirement is not specifically related to the appropriate unit question, but rather, more generally, to whether a question concerning representation exists. Thus, although now the Board will in most cases render a decision on one subsidiary issue - the scope of the appropriate unit - on the basis of this rule, the Board will resolve other issues, such as whether a contract bar exists, whether certain employees are supervisory or managerial, whether the petitioner is a labor organization or has a conflict of interest, whether a single facility unit is appropriate, the composition of the appropriate unit, etc. on the basis of testimony taken at the hearing. The Board has merely determined that the issue of the scope of the appropriate unit within an acute care hospital does not generally require adjudicatory consideration, and that otherwise it would have "continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." *Heckler v. Campbell*, supra at 467.

neither feasible nor helpful. Only the Board members themselves can resolve contested cases, including unit issues. *KFC National Mgmt. Corp v. NLRB*, 497 F.2d 298 (2d Cir. 1974). The Board normally decides representation cases (as well as other cases) by panels of three members, and to create a permanent panel of three would not be likely to improve efficiency, and instead might result in delay. Moreover, it would unjustifiably exclude the other two members. Because of the volume of cases before it, the Board simply cannot hear oral arguments except in very unusual cases, and we are aware of no useful purpose that would be served by sending Board members to regional offices to decide health care cases. Sitting in the locale of the contested case would not add to the members' understanding of the case.

Some commenters suggest the use of rebuttable presumptions. The Board has previously rejected that suggestion, for the reasons set forth in NPR at 52 FR 25145. The Board's experience since 1974 is that painstaking elicitation and examination of the facts of each individual case is, absent extraordinary circumstances, neither helpful nor outcome determinative as to the scope of the appropriate unit. See NLRB Exhibit 5, revised, referred to in NPR II at 53 FR 33903. The use of mere presumptions would not eliminate the duplicative litigation referred to by the Supreme Court in *Heckler v. Campbell*, but establishing units by rulemaking will go a long way towards accomplishing that objective.

Finally, although we are highly satisfied with this rulemaking proceeding both because of the large amount of valuable information it has given us and because, based on that information, we are confident we have

moved towards eliminating much of the unnecessary uncertainty existing in this area, we are under no illusions that the answers we now provide will necessarily solve all health care unit problems, for all time. This is our first venture in major, substantive rulemaking. At some future date, after the rule has had a fair trial, it may be appropriate to reexamine the rule to determine how well it has worked, whether new developments have changed our underlying assumptions and require different conclusions, and whether some other provisions might improve those now promulgated.

III. Cost Considerations

Strikes and strike costs were dealt with at some length in NPR II. (53 FR 33908-33910.) Though the comments following NPR II did not challenge the Board's finding there that the incidence of strike activity in the health care industry has been lower than in all other industries (53 FR 33908), industry commenters identify approximately 20 strikes that have taken place. A number of employers report that they have experienced one strike (e.g., Comment 1706, Ellis Hospital; Comment 1718b, Waterbury Hospital Health Center; Comment 1654, Pottsville Hospital and Warne Clinic; etc.). Two commenters report multiple strikes (Comment 1145, East Liverpool City Hospital, four in 20 years; Comment 1249, Santa Rosa Memorial Hospital, two strikes in last 8 years totaling 70 days plus four 10-day strike notices).

The evidence in NPR II showed that sympathy strikes in hospitals have been virtually nonexistent. (53 FR 33909.) Nonetheless, two hospitals now report sympathy

strikes. (Comments 1259 and 1729b, Bridgeport Hospital, regarding Waterbury Hospital; Comment 516, Saint Elizabeth Medical Center (sympathy strike by delivery drivers at unnamed hospital).)

The strikes reported in the aforementioned comments are insufficient in number or character to conflict with the Board's prior conclusions in NPR and NPR II.

A few hospitals discuss costs relating to their strikes. For example, in Comment 981, O'Bleness Memorial Hospital reports spending \$20,000 for security forces and over \$20,000 for legal and negotiating fees; two of the three times the hospital renegotiated its contract, the union issued a strike notice and the hospital incurred costs in strike preparation. Pottsville Hospital and Warne Clinic reports \$20,000 in legal fees and staff time (Comment 1654). The only cost amounts we regard as possibly noteworthy involve Wadley Regional Medical Center and Santa Rosa Memorial Hospital. In Comment 937, Wadley states that, in 1978, its costs for a strike were "up to \$1,000,000." Santa Rosa, in Comment 1249, reports its labor relations costs relating to two strikes, four strike notices, and three organizing campaigns, were "up to 5 million." In both instances, and in the absence of elaboration, the hospitals' use of the phrase "up to" leads us to believe that the amounts given are only upper-limit estimates and not careful calculations. Nor is there any indication whether these costs were largely wage increases, legal fees, lost revenues, overtime, remuneration of striker replacements, or even lost profits. Legal fees are, of course, highly individual. Where cost estimates include staff time, it is not clear how much of the staff's time was ordinary expense precommitted to be paid

regardless of whether there was a strike. See, e.g., Comment 1654, Pottsville. In any event, the costs of the small number of strikes mentioned do not seem disproportionate to what we believe Congress must have anticipated when it authorized collective bargaining in the health care industry by placing it under the Board's jurisdiction in 1974.

Approximately twelve commenters provided information regarding costs of bargaining. For example, in Comment 1684, Mon Vale Health Resources, Inc. reports it spent \$40,000 in the last negotiations with its non-professional unit and \$8,000 for arbitration. In Comment 1714, Gerald Champion Memorial Hospital reports \$16,000 for each of its negotiations. In Comment 1143, Lakeland Hospital estimates the cost from its one non-professional unit as \$15,000 to \$25,000. In Comment 1476, Brookhaven Memorial Hospital reports the cost of one unit's organizing campaign as 24 days of hearings and lost productivity, and \$80,000 in legal fees. It is the Board's expectation that its promulgation of this rule establishing appropriate bargaining units will render lengthy scope-of-unit hearings unnecessary and to that extent some costs, such as legal fees, will therefore diminish. In any event, it would not be suitable for the Board to reject appropriate bargaining units on the basis that the very things sought by collective bargaining – negotiating and grievance processing – can be obtained only at some financial cost. The statutory amendments enacted by Congress in 1974 represented an implicit policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the cost.

IV. Employer Flexibility

Four commenters take particular issue with the Board's reasoning that rulemaking has no logical connection with an employer's continuing ability to respond flexibly to changing needs of the times. (53 FR 33904; see also 53 FR 33910).

Martha Jefferson Hospital (Comment 884A) argues that employees will resist change by seeking to join one of the units deemed appropriate. That argument has no support in the facts adduced during this proceeding; there has been no showing that unions have resisted changed job duties. Moreover, logically, the argument, if valid, would apply to some extent regardless of what units the Board finds appropriate, and regardless of the method the Board utilizes to determine the scope of appropriate units. It is true that union organization does lead to the requirement that employers bargain before making changes in wages, hours, and working conditions, but that is an obligation imposed upon all employers by the NLRA, and we have no basis upon which to exempt health care employers from these requirements. There has been no demonstration of undue resistance to change by health care unions.

The University of New Mexico Hospital (Comment 1022) suggests that jurisdictional disputes may arise but offers no examples to support its speculation; few if any were offered in the earlier stages of this proceeding either. (53 FR 33909). Based on the evidence presented to us, we conclude that jurisdictional disputes are infrequent in the health care industry generally. If such disputes were to arise, section 10(k) of the Act would be

available to assist in resolving them. Moreover, if there were several units in a facility, it is possible they would be represented by the same labor organization, which might work things out by itself.

Allegheny Health Services (Comment 1094) reasons that implementing a hospital-wide fitness policy, for example, including drug testing, would be more difficult or even impossible if bargaining had to be held with eight separate units. Even if that is true, the evidence shows that, at least in the past, very seldom have hospitals had more than two or three units. (52 FR 33933). Moreover, though no specific evidence was offered on this point, we suspect that other hospital-wide policies, such as holiday and vacation schedules, cafeteria benefits, parking privileges, etc., are uniform at many hospitals despite the presence of several units. Lastly, if one is to speculate, it could be argued with equal logic that an employer might have better success in negotiating a new plan with one small unit's representative, implementing that, and later using it as precedent for changes elsewhere, than it would in negotiating a new plan with a single labor organization representing many types of employees with diverse interests.

Taft, Stettinius & Hollister (Comment 1330) refers to a proposal by the American Medical Association for a new classification, RCT (registered care technician), in which employees could move up from aide to LPN to RN as they received additional training. Taft, Stettinius argues that, under the Board's proposed rule, employees within the RCT classification would be in three different units and therefore hospitals will lose flexibility in using RCTs. However, insofar as employees are in fact aides,

LPNs and RNs, they are, for reasons set forth in NPR and NPR II, entitled to be in separate units, and creating a new generic classification of RCT does not change that fact. Nor would any RCT be in more than one unit at a time, even though he or she might, over time, progress from one unit to another. In any event, at this time the development and implementation of the RCT classification is speculative. Taft, Stettinius' additional comment that hospitals would have to structure their staffs to conform to the proposed rule is supported neither by evidence nor reason. Physicians will still practice their specialty, as will RNs, technicals, etc. Nothing in the rule precludes hospitals from structuring their operations as they see fit.

V. Common Expiration Dates

In NPR II, the Board noted that "hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes." (53 FR 33909). The AHA argues (Comment 1711) that "common expiration of multiple contracts virtually would insure a complete cessation of operations, and thus, is an illogical, unworkable goal for hospitals to pursue or for the Board to use as support for its conclusions here." See also Comment 987, Dana-Farber Cancer Institute, which suggests that the Board should not criticize the health care industry for not availing itself of common expiration dates because there have been crippling strikes in New York, Minneapolis, and San Francisco as a result of the strategy of common expiration dates.

We accept the criticism of these commenters, but their argument proves too much. Simultaneous strikes that may occur on the occasion of common expiration dates would seem to support more rather than fewer units. An obvious characteristic of a large bargaining unit would be that all employees' no-strike obligations would expire at the same time, and bargaining for the entire unit would take place at the same time. Although a small unit's work stoppage may not shut down the entire facility, a large unit's stoppage surely will. This point was made in NPR II, at 33909; see also *Manor Healthcare Corp.*, 285 NLRB No. 31 (1987), slip op. at 13, where the Board pointed out that "an employerwide unit in this situation would tend to broaden a given dispute and increase the potential for disruption of patient care."

VI. The Units

Surprisingly few comments offered additional facts which would be helpful to the Board in making a final decision with regard to the appropriateness of particular bargaining units.

Some additional information on teams was proffered, but the Board reaffirms its earlier conclusion as to the limited relevance of the so-called "team approach." See NPR II 33907; 33913. A few commenters state they have teams, like discharge planning, but do not detail interaction or demonstrate why separate units would prevent use of teams. One commenter, Bethesda North Hospital (Comment 1303), acknowledges that each discipline retains its particular area of accountability, but argues that "it is vital to the progress of the patient that they

each understand and can cross over into each other's area" See also Comment 1044, Missouri Hospital Association, which emphasizes that the Board has conceded the existence of teams, however widespread they may be.

On a related point, several commenters give examples of cross training. Comment 586, Marshalltown Medical and Surgical Center, describes its practice of having security guards work the switchboard and do maintenance work. However, such employees would necessarily be placed into the statutorily-mandated separate guard unit. Attached to Comment 586 is a newsletter from George E. Speese, a Human Resource Development consultant, who describes how an East Oregon hospital assigned switchboard duties to a "radiology tech," and how a Philadelphia hospital assigned nursing unit clerical duties to a phlebotomist. Similarly, Comment 1053, La Grange, states that certain non-unit jobs were performed by unit employees (dietary employees performed some outside maintenance duties, certified nurses' assistants performed some clerical duties, etc.). In such situations, La Grange argues, the Board's proposed rule would require it to carve out skilled maintenance and clerical functions into separate units. However, this argument is based on a misunderstanding of Board unit determinations as well as of the provisions and purposes of the rule. Board unit determinations do not require that certain types of work be assigned to any particular unit. To the contrary, employers are free to make whatever work assignments they wish, subject of course to their obligation to bargain before making any changes in working conditions. Where one employee is assigned functions relating to more than one unit, he or she is a "dual

function" employee, and, upon request, the Board will determine the unit placement of such employee. See, e.g., *Otasco, Inc.*, 278 NLRB 376 (1986); *Oxford Chemicals, Inc.*, 286 NLRB No. 13 (1987). In neither of the cited cases did the Board impose any restrictions on the employer's making cross-unit assignments; neither has the Board imposed such restrictions in any other case of which we are aware.

La Grange's comment also refers to medical technicians' being trained in at least 3 areas, including hematology, bacteriology, and histology. This comment is consistent with the observation of NPR II that "the majority of cross-training that occurs is among the technical categories themselves." NPR II at 33919.

Comment 1081, Wausau Hospital Center, discusses product line management. Employees have to work together, and sometimes are even supervised by an individual who may not be their direct line supervisor. The comment states that the Board misunderstands this concept and that multiple bargaining units jeopardize this program. As with cross-training, discussed above, this commenter does not explain how the Board's unit determinations would in any manner inhibit product-line management.

A small amount of additional information was offered as to the proposed separate RN unit. See Comment 1026, by Spelman Memorial Hospital, that, with 128 beds, RNs report to the same administrator as lab technologists and physical therapists. Moreover, RNs work in medical records along with other professionals. Comment 1330, Taft, Stettinius & Hollister, asserts that RNs are not

unique, since other professionals also have direct and continuous patient interaction, etc. This comment concedes that RNs are the "hub" of the professional administration of health care, but argues that to remove the hub and separate it from the spokes will cause the wagon to break down. Comment 1675, Middletown Regional Hospital, states that some of its nurses' former work is now done by social workers, and that nurses at this hospital share the same pay system and pay, as well as some common first line supervision, with other professionals.

The comment of Taft, Stettinius that all professionals interact with patients, fails to give sufficient weight to the adjective "continuous." The uniqueness of the RNs' function in this regard was thoroughly dealt with in NPR II at 33911, V, B, 2. The fact that in smaller hospitals there may be some common supervision does not cause us to reach a different result, particularly in view of the very few examples presented.

In Comment 1044, Missouri Hospital Association, through its attorneys, Spencer Fane Britt & Browne, takes issue with the Board's observation in NPR II that nurse licensing exams are uniform throughout the country. However, at TR 3595-98, witness Faith Reiersen described national licensing exams in considerable detail. The National Council of State Boards of Nursing consists of the executive secretary and the members of the various nursing boards in the 50 states and 3 territories. Each of the states and territories has contracted with the National Council to provide that state or territory's licensing examination for RNs and LPNs. The same test is administered twice a year on the same day at the same time

(except for time zone variations) in each of the states and territories. No contrary testimony was introduced.

On January 19, 1989, the Secretary of Health and Human Services made public the report of his Commission on Nursing. This Commission was an advisory panel appointed to examine reports of a widespread shortage of registered nurses, and to make recommendations for resolving the shortage. We have examined the Commission's Report and find that it supports our observations in NPR II concerning the nursing shortage, unique problems confronting nurses, and the special need of nurses for their wage compression to be alleviated.

In Comment 975, American Physical Therapy Association urges the Board to create a separate unit for physical therapists, in part because of their separate licensure. The practice of physical therapy is administered in almost all jurisdictions by a separate board. The commenter represents, and it is undoubtedly true, that physical therapists have concerns peculiar to their speciality, such as interpretation of their practice act, private patient referral and access, home care extension services, and experimental structures for student clinical supervision. However, especially in view of their relatively small numbers and their limited history of separate bargaining (in New York, largely), as well as the Board's desire to limit the number of units unless there is strong justification presented in the rulemaking record, the Board declines to establish a separate unit for physical therapists. If found to be professionals, they are to be included with other non-RN and non-physician professionals. See NPR II at 33917-33918.

The Board affirms the appropriate unit findings made in NPR II, for the reasons set forth therein, and except to the extent modified in this Final Rule and accompanying Supplementary Information.

VII. Small Units

A number of commenters argue that the proposed "skilled maintenance" and "other professional" units, in particular, may be too small for collective bargaining purposes. See, e.g., Comment 1686, American Society for Personnel Administration, which represents that skilled maintenance frequently constitutes less than 2% of the workforce. See also, generally, Comment 905, Humana; Comment 562, The Methodist Hospitals (Indiana); Comment 1021, St. Elizabeth's Hospital; Comment 1044, Missouri Hospital Association; and Comment 1330, Taft, Stettinius & Hollister, Blanchard Valley Hospital (Comment 369), referred specifically to excessive administrative costs that may be associated with negotiations for very small units.

We recognize the possibility that some skilled maintenance units will be relatively small, as will some "other professional" units and some physicians' units. The same point has been made with respect to rural hospitals, whose small employee complements may also lead to very small units.³ St. Vincent Hospital (Comment 1691)

³ Parenthetically, we noted that a large number of small rural hospitals call attention to their precarious financial condition. Comment 333, Holy Rosary Medical Center; Comment

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argues that in a Coronado Hospital with 105 beds, there would be bargaining units of 1-2 persons. In Comment 1044, Missouri Hospital Association hypothesizes that in a hospital of 20 beds, there might be more units than patients.

We doubt this situation will frequently arise. For one thing, it is likely this "problem" will be self-policing. Where the entire workforce is very small, we believe that even smaller sub-groups will seldom want separate units; nor will unions be likely to organize such small units. Moreover, we note that under adjudication, the Board rarely if ever reached different results because of the size of facility. In only one case, to our knowledge⁴, did the Board arguably reach a different result because of the number of employees involved. In *Mt. Airy Psychiatric Center*, 217 NLRB 802, 803 (1975), one of the earliest cases decided after the 1974 amendments, the Board included two employees who *arguably* were technicals in the service and maintenance unit, since they were the only employees performing a "technical" function. Lastly, the Board did propose a 100-bed dividing line with fewer units for smaller hospitals in the first NPR, but industry

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1300, Bowie Memorial Hospital; Comment 1307, United Hospital Center; Comment 1673, Grayson County Hospital; Comment 967, Northern Maine Medical Center; Comment 1700, Weston County Memorial Hospital and Manor; etc. We do not consider the financial condition of rural or small hospitals relevant to a determination of appropriate bargaining units.

⁴ But see also *Extendicare of West Virginia, d/b/a St. Luke's Hospital*, 203 NLRB 1232 (1973), which arose prior to the 1974 amendments.

and labor organizations were virtually unanimous in their opposition to it (53 FR 33927).

Despite the foregoing, and despite the improbability that the problem will frequently arise, we agree that units of two or three employees, or of similarly small numbers of employees, would in many cases be impractically small, especially in the health care industry. Where so few employees are involved, it can be argued with some degree or persuasiveness that despite the shared, unique concerns and backgrounds that would otherwise make the separate units appropriate, these concerns are outweighed by concerns over disproportionate, unjustified costs and undue proliferation of units. We therefore shall revise the rule to provide that a petitioned-for unit of five employees or fewer shall constitute an "extraordinary circumstance" removing the case from strict application of the rule, and the Board will consider by adjudication what the appropriate scope of the unit should be.⁵

⁵ Though, based generally on our prior experience as well as the evidence accumulated during this rulemaking proceeding, we have decided that a unit of five or fewer employees automatically triggers the "extraordinary circumstances" exception, we recognize that there is no ineluctable logic in the number five, and that other situations may occur in which a party may contend that the number of employees in the petitioned-for unit, or other circumstances, may require deviation from strict application of the rule. Thus, the "extraordinary circumstances" exception remains available (most commonly through an offer of proof - NPR II at 33933) for any party who wishes to argue for any reason that the rule should not be applicable to its facility. At the same time, we reemphasize that we do not intend for the "extraordinary circumstances" exception to "provide an excuse, opportunity, or 'loophole' for

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We recognize that situations involving small units may vary. Thus, in some situations, if the requested units were not deemed appropriate, the small, requested unit might have to be added to a vastly larger unit. On the other hand, a requested unit falling within this extraordinary circumstances exception might be considered in conjunction with one or more otherwise appropriate units of approximately the same size. Requiring a combination of these otherwise separately appropriate groupings may give rise to considerations different from those in the previous example. The Board will render appropriate decisions through its adjudicatory processes when the extraordinary circumstance provision is invoked in this situation. This approach will allow us to examine individual circumstances where justified, while eliminating unnecessarily repetitive litigation.

VIII. Equal Employment Considerations

Comment 1098, Myerson & Kuhn (position paper by Susan Warner), represents that RN units are dominated by females, 95-98%; physicians are dominated by males (primarily white), in one large medical center, 83%; technicals are dominated by females, 72-78%, with less than 50% minorities; other nonprofessionals are dominated

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redundant or unnecessary litigation." NPR II at 33932. The Board will not reconsider, under the "extraordinary circumstances" exception, the arguments it has already rejected in this exhaustive proceeding.

90% by minorities; business office clericals are predominantly female, and almost 50% white; and skilled maintenance is 85% male, 75% white. This commenter observes that hospitals are subject to Title VII of the Civil Rights Act of 1964, and argues that the proposed rule will defeat hospitals' efforts to integrate their workforces and provide opportunities for minorities and women. Hospitals will be hampered by negotiations with unions representing what are in effect segregated units, insuring that these units remain segregated. She points particularly to seniority and says most collective-bargaining agreements do not recognize seniority from other units, thus impeding upward mobility. Warner's cover letter expresses the opinion that this aspect has not been adequately explored and requests that the Board extend the comment deadline for this purpose. Her remarks are echoed by Comment 1508, Thomas Jefferson University Hospital.

This is a question that has previously concerned us also, and during the first round of hearings the Board's representative specifically asked, twice, for comments on this subject (see TR 5225, 5243), noting that former-Member Jenkins had raised the same question during the 1975 oral arguments held shortly after passage of the amendments.

Only two witnesses addressed the subject: Jerry Shea, SEIU's Director of the Health Care Division; and Cathy Schoen, consultant to SEIU and its former Research Director. Both testified at some length, answering questions raised by management attorney Roger King. Schoen submitted a supplemental statement addressing it further. SEIU has represented over a quarter million workers in the health care industry, through 80 separate locals.

The testimony of Shea and Schoen was that "balkanization," or rigid stratification within classifications, with little upward mobility, has been characteristic of the entire health care industry, representing the attitude of most employers that they would rather not lose a good worker and have not deemed it in their interest to provide training for promotions to other classifications; this has been done for bureaucratic and not for nefarious or uncaring reasons. They testified that the medical "model" characteristically organizes access to positions through outside education and licensure certification as opposed to, for instance, the apprenticeship model that operates in the skilled trades.

Schoen testified there is in effect a caste system, with employers preferring departmental seniority regardless of whether or not there is unionization, and that it has been unions that have attempted to break out of this system. (TR 5221 ff.) Frequently even with broad units there is departmental seniority. (TR 5242.) Some subgroups have successfully bargained for seniority across unit lines. (TR 5244-45.) In her Supplemental Comments, Schoen gives as examples of these exceptional cases Mt. Sinai in Chicago, where SEIU secured hospital-wide seniority for business office clericals, as well as bumping rights in the event of layoffs and Cape Code Hospital, where SEIU successfully negotiated hospital-wide mapping of jobs according to skills and entry level requirements, so employees could better see mobility paths. Schoen also notes the SEIU Local 250 contract for Kaiser in Northern California, covering 9,000 workers from service staff to pharmacists; there, seniority and promotion

accrue first by department, then by facility. Schoen concludes that there "is a narrow administrative orientation towards human potential that limits mobility - not the units in which workers choose to organize." A footnote to Schoen's Supplemental Comment lists three studies on this subject. Brief reference was made to this evidence in NPR II at 33910.

In view of the Board's express invitation on the record for further evidence on this subject, and the limited substantive response, the Board does not see a need for additional discussion. Having considered the comments and the record evidence on this issue, the Board affirms its prior conclusion that the evidence fails to show that the units found appropriate will limit minorities' or women's opportunities for job advancement and security, and may possibly have the opposite effect. (53 FR 33910.)⁶

⁶ In one adjudicated case, the Board adopted the conclusion of an administrative law judge that a bargaining unit limited to a coke department continued to be separately appropriate even through one of the parties alluded to a formal consent decree (*U.S. v. Allegheny-Ludlum Industries*, 63 F.R.D. 1 (N.D. Ala. 1974), affd. 517 F.2d 826 (5th Cir. 1975), cert. den. 425 U.S. 944 (1976)), the primary objective of which was to create transfer opportunities so that employees in departments like the coke department could move into other departments with higher skills. The purpose of the consent decree was to alleviate past alleged discrimination on the basis of race, sex, color, and national origin. As indicated, the Board found accretion was not appropriate, despite the existence of the consent decree. *Armco, Inc.*, 279 NLRB 1184 at 1184, 1214-15, 1218-19 (1986).

IX. Coverage of the Rule

Though not objecting to the Board's exclusion of nursing homes from the proposed rule, the AFL objects to the Board's summation of the evidence (NPR II, Section XII, at 33927-29), suggesting that the Board's conclusions might not be accurate and might prejudice future rulemaking by referring to lack of uniformity among nursing homes. Though we agree that our information as to nursing homes has been limited, we do not agree that this part of the prior Supplementary Information will in any way prejudice future proceedings that might involve nursing homes. Such proceedings would be based on evidence presented herein.

Only one commenter would include psychiatric hospitals, Comment 322, Union of American Physicians & Dentists. That suggestion was made not on the basis of specific facts or arguments on the merits, but rather because, in view of the many instances of common ownership and interlocking directorates, it would allegedly be relatively simple for "devious" attorneys to make a given facility fit within an exclusion. We have no good reason to believe that parties will attempt to dupe the Board into thinking that an institution is not what the facts make it out to be. In any event, such a remote possibility is an insufficient reason for including a type of facility which the Board finds, for reasons explained in NPR II at 33929-30, should not be covered by the proposed rule. We shall continue to exclude psychiatric hospitals from coverage of the rule.⁷

⁷ The same commenter requests the inclusion of non-acute care facilities such as HMO's for the same reason. We similarly reject this request.

In NPR II, the Board noted that it did not have much evidence on rehabilitation hospitals and various other specialty facilities, and so these facilities were "tentatively" included. See NPR II at 33931. Those who had commented had argued that care was integrated, but did not urge special treatment. NPR II, Section XIV.

New England Rehabilitation Hospital, Comment 952, represents that it is solely a rehabilitation facility, but that average patient stay has been decreasing and last year was just under 30 days. It documents more completely the integrated care required for comprehensive rehabilitation. For one thing, as with psychiatric hospitals, RNs are not the primary facilitators of patient care, and are significantly outnumbered by other professionals. Teams are used not only for special situations, but carry out day-to-day treatment for each and every patient. In all cases there is close integration between the work of RNs and that of physicians, therapists, social workers, psychologists and dieticians. RNs are not left to themselves on off-shifts; therapies are conducted on weekends, and social workers meet with patients and families evenings and weekends. Similar information is offered by Comment 1273. The Rehab Hospital of York, which states that its occupational therapists, physical therapists, and speech therapists continuously collaborate with physicians and RNs to develop and provide treatment for all patients. New England Rehabilitation Hospital has 198 beds; The Rehab Hospital of York, 250 employees.

The most extensive comment addressing this issue was that submitted by Specialty Hospital Group, part of National Medical Enterprises, Inc., Comment 970. That group includes 53 freestanding psychiatric hospitals, 23

freestanding rehabilitation hospitals, 18 freestanding substance abuse treatment facilities, and 100 managed facilities of the three varieties. First, it describes how AHA registers some hospitals as "rehabilitation" hospitals; average length of stay is not involved. Second, Congress exempts rehabilitation hospitals from Medicare's prospective payment system, and implementing regulations (42 CFR 4052) contain a specific, 7-part definition of a rehabilitation hospital. Rehabilitation hospitals may also be accredited by one of two bodies: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), under different standards from those applied to regular hospitals, or by Commission for Accreditation of Rehabilitation Facilities (CARF). Accreditation by JCAHO or CARF automatically satisfies six of the seven criteria constituting the definition for Medicare prospective payment exclusion purposes: All except the requirement that, during the most recent 12-month reporting period, 75% of the inpatient population required intensive rehabilitative services for the treatment of one or more of certain specified conditions. Thus, exclusion of rehabilitation hospitals would be administratively feasible, claims this commenter.

Specialty Hospital Group further points out that one of the accreditation standards under the Medicare definition requires multidisciplinary care. Each patient must have at least three hours of physical or occupational therapy per day for Medicare to pay for the care as "medically necessary"; therefore, it is argued, nurses are not the primary facilitators of care in rehabilitation hospitals. Moreover, for Medicare coverage to apply, rehabilitation hospitals' patients must be medically stable before

they are admitted. Thus, it appears that the level of acuity at rehabilitation hospitals is considerably lower, and generalizations about job classifications and appropriate units at other types of hospitals may not apply.

Specialty Hospital Group does not ask for exclusion of alcohol and drug abuse hospitals (if there are any), but for clarification of the rule to make it clear that alcohol and drug abuse residential treatment facilities that are not hospitals are not covered.

The rule previously proposed covers only "acute care hospitals." An acute care hospital is defined as a "short term care hospital in which the average length of patient stay is less than thirty days." It seems likely that the acute care definition would exclude many rehabilitation, as well as drug and alcohol, facilities. Yet, if it is true, as New England Rehabilitation Hospital represents, that its average length of stay is now slightly below 30 days, such a hospital would be covered by the rule previously proposed, as an acute care hospital.

The Board has considered the comments submitted at this stage of the proceeding, pertaining to rehabilitation hospitals, and has decided that sufficient questions have been raised about appropriate units at such facilities that the rule should not be applied to rehabilitation hospitals. Many of the reasons given by the Board in NPR II for the exclusion of psychiatric hospitals (NPR II at 33929-30) now appear applicable to rehabilitation hospitals as well. Thus, for example, it appears that RNs may not be identifiable as the primary professional providers of patient care; RNs and other employee classifications function somewhat differently because patients are not as acutely

sick as in other types of hospitals, and because different methods of treatment appear required for rehabilitative care; and around-the-clock efforts may be more extensively required of all professional groups, and perhaps other employees as well. The Final Rule will not, therefore, cover rehabilitation facilities that have been accredited as such by either JCAHO or CARF, regardless of the average length of patient stay.

With respect to inpatient drug and alcohol treatment centers, it is possible they would be excluded either by (a) the definition of "acute care," relating to length of patient stay; or (b) the new exclusion for rehabilitation hospitals generally. No case has been made for exclusion of all drug and alcohol treatment facilities as a class, and regardless of whether they are hospitals. However, if particular drug and alcohol facilities are not hospitals, the rule is not intended to cover them. For purposes of clarification we have decided to include in the rule a definition of "hospital," apart from the definition of "acute care." The definition shall be that contained in the Medicare Act, currently to be found at 42 U.S.C. 1395x(e), as revised in 1988, and incorporated by reference in the Final Rule's definitions.

X. Miscellaneous Problems

(a) *Definition of "acute care."* AFL contends that use of the "acute care" definition in NPR II might "skew" the average length of stay if a hospital has a large number of long term beds or swing beds. AFL points out that AHA alternatively defines a "short term" hospital as one in which over 50 percent of all patients are admitted to units

where the average length of stay is less than 30 days." In view of the very high patient acuity level in hospitals today, we doubt that there would be many situations in which a sufficient number of long-term days by a few patients would skew the average. However, we agree with AFL that the Board's intention may be better realized by addition of the alternative definition. One long-term patient in a small, otherwise acute care hospital should not serve to define the character of the hospital. Accordingly, we shall revise the Final Rule to encompass the alternative definition as well.

(b) AFL suggests that parties may try to persuade the Board that, even though a facility is not "primarily" any one of the excluded types of institutions, it still is not "primarily" an acute care hospital, perhaps because it has such a variety and/or multiplicity of other types of units it is not "primarily acute care," but rather some other amalgam type of institution. The concern of this commenter may be well placed. Many of today's hospitals have a number of other types of units, such as outpatient clinics, nursing care units, etc., and the Board did not intend to exclude such hospitals from coverage of the rule unless any one of the excluded ancillary services predominated. Nor did the Board intend to permit a hospital to argue successfully that since the number of its outpatient visitors exceeded the number of its over-night (acute care) patients, it was not an acute care hospital, and therefore not subject to the rules. In order that there not be unintended litigation, we shall, in the Final Rule, delete the initial reference to the primary purpose of the hospital.

(c) AFL suggests that the Board establish a reference point for average length of stay, such as "the most

recent twelve months preceding receipt of a representation petition for which data is readily available." We doubt that, with respect to this issue, individual hospitals will substantially vary depending on which 12-month period is utilized. However, for purposes of clarity, we shall revise the rule to encompass this suggestion.

(d) AFL further suggests that, where a petition is filed under the rule, and a hospital claims not to meet the definition of "short-term hospital," the burden should be on the hospital to produce the evidence, since the records would be in its sole control. The AFL is suggesting a *Tropicana*-type rule (*Tropicana Products, Inc.*, 122 NLRB 121 (1958)) for use in situations in which a hospital does not come forth with the necessary information. We trust this will not prove to be a major concern, since in the normal case it will be obvious whether a hospital is acute care or not; stipulations should usually be obtainable. However, in order to encourage the party in sole possession of the records to cooperate, we shall amend the proposed rule to provide that, where the employer does not, after issuance of a subpoena, produce records sufficient for the Board to determine the facts, the Board may presume the employer is an "acute care hospital."

(e) AFL urges the Board to reconsider and hold cases pending the effective date of the Final Rule. Alternatively, it urges the Board to use its new empirical knowledge and, for example, grant RN units even under the latest disparity of interests test. The same point is made, in more detail, by Comment 1710, American Nurses Association (ANA). The Board has not held cases pending the effective date of the Final Rule (see, e.g., *Middletown Hospital Association*, 291 NLRB No. 79 (Oct.

28, 1988)), although parties themselves may have refrained from bringing cases during this interim period; few have come to the Board since NPR II. Whatever the merits of the AFL's suggestion, and that of ANA, it is now moot.

(f) AFL suggests that, "to make the rule consistent with the preamble, it should state that a unit may be combined when petitioned for by a union. This would preclude an employer from arguing that only a combination unit is appropriate." That is, of course, the intent of this provision of the rule, as explained, with citations, in NPR II at 33932 (Sec. XIX, Combined Units). The long-standing principle of *Morand Brothers Beverage Co.*, 91 NLRB 409 (1950) (cited NPR II at 33932) continues to apply, and we shall make the required addition to the rule to clarify this point.

XI. Placement Decisions

Comment 1107, American Association of Nurse Anesthetists, asks for case-by-case consideration of whether certified nurse anesthetists properly belong in physicians' units or RN units. Such consideration will, of course, continue to occur, as the Board implied in NPR (at 25146, noting that some day in the future perhaps rulemaking would be utilized to determine unit composition), and NPR II (at 33926, stating "The precise placement of particular classifications which may be disputed in a particular case, is, for the time being, left to the case-by-case adjudicative approach.")

For the same reasons, we deny the request of American Society of Clinical Pathologists (Comment 1329) to

clarify the rule to specify that ASCP-certified medical lab technologists are to be included in "other professional" units, and certified medical lab technicians are to be included in technical units. The Board in this rulemaking proceeding at the outset disclaimed any intention to determine placement issues (NPR at 25146), and it would be inappropriate to deviate from this stated intention, even if the record were sufficiently complete to permit us to do so.

XII. Extraordinary Circumstances

AFL suggests that some of the limitations on the extraordinary circumstances exception set forth in the Supplementary Information accompanying NPR II (Section XX at 33932-3) be incorporated into the Final Rule. AFL suggest, e.g., that the rule should provide:

Extraordinary circumstances exist only where a hospital is shown to be uniquely situated such that application of the rule would be accidental or unjust. Variations among acute care hospitals that were considered by the Board in promulgating this rule do not, alone or in combination, constitute an extraordinary circumstance.

AFL also asks that the rule make it clear that multi-site units are not an exception. The Board has considered these suggestions, but fails to see the necessary for including these matters in the Final Rule.

Several commenters suggest that the extraordinary circumstances exception is so narrow as to be useless

AHA argues that, because of the narrowness of the exception, parties would be deprived of due process. (Comment 1711.) However, the case cited for that proposition, *Jackson Water Works, Inc. v. Public Utilities Comm.*, 793 F.2d 1090, 1097 (9th Cir. 1986), merely states as a general proposition that "the due process clause guarantees an aggrieved party the opportunity to present a case and have its merits fairly judged (citations omitted). (S)ome form of 'hearing' is required before a person is deprived of a protected property interest." Aside from the question whether a constitutionally-protected "property" interest is involved when the Board makes a unit determination in a representation proceeding, it is clear that the hearing required by section 9(a) of our Act will continue to be available where the parties do not consent to an election. *Supra*, Section II, and, specifically, n. 2. We note, coincidentally, that the majority in *Jackson* held that the state's eminent domain procedure was constitutional, even though it provided for no right of appellate review. See also Comment 1330, Taft, Stettinius & Hollister. Comment 1087, California Association of Hospitals and Health Systems suggests that the extraordinary circumstances exception is so narrow that its inclusion is "a charade."

We do not agree with these commenters' characterizations. The purpose of the rulemaking procedure has been to gather a large amount of information, and then to set forth unit determinations consistent with the information gathered, appropriate for collective bargaining purposes, and consistent with the Board's obligations under the statute. The Board's experience since 1974, as documented in Board Exhibit 5, as amended, has been that, even under adjudication, with the facts of each individual

case recited in records of substantial length and expense, the Board has almost always reached the same result. That being true, avoidance of unnecessary litigation in each case has been one goal of the rulemaking undertaking. The extraordinary circumstances exception has had to be crafted in such a way as to satisfy due process by allowing for litigation where the circumstances warrant, i.e., are truly extraordinary – but at the same time precluding litigation where the arguments are merely repetition of matters already considered, such as the team approach, integration of functions, cross training, increased specialization, recent cost containment measures, etc.

We have, in this SUPPLEMENTARY INFORMATION, provided specifically for one “extraordinary circumstance,” viz, a requested unit of five employees or fewer. There will undoubtedly be others, but we do not expect them to be frequent. We find nothing inconsistent with due process in the “extraordinary circumstances” exception crafted into the Final Rule. We reaffirm the scope of the extraordinary circumstances exception as set forth in NPR II.

XIII. Proliferation

A number of commenters dispute the Board’s conclusions on proliferation in NPR II at 33933-94. Comment 1087. California Association of Hospitals and Health Systems, takes issue with the Board’s analysis in NPR II, that Congress was concerned with patterns such as in newspaper and construction industries of fifteen or more units at a workplace. That commenter argues that Congress’

failure to specify a number does not justify the Board’s speculation that eight units would satisfy Congressional concern. Comment 1330, Taft, Stettinius & Hollister, contends that the Board erroneously analyzed the legislative history. Taft, Stettinius believes that the parties did not reach a compromise whereby employers gave up statutory limitations on the number of units in return for stroke-restricting provisions; neither did unions win the right to use the five-unit specification as a floor. Comment 1686, American Society for Personnel Administration, contends that no other industry has as many units as the Board has given in this proceeding. Comment 1711, AHA, argues that the Board errs in believing that Congress merely wanted the Board to avoid patterning health care units after the newspaper or construction industries, stating that this argument was rejected by the Second Circuit in *Mercy Hosp. Assn.*, 606 F.2d 22, 27 (2d Cir. 1979), cert. den. 445 U.S. 971 (1980), which said that even application of the normal industrial unit criteria could impede effective delivery of health care services.

The subject of what Congress meant has been debated since 1974, with opinions varying from those expressed by the Board in NPR II, to those expressed by some courts as indicated above, to those expressed by Judge Edwards in *Electrical Workers IBEW Local 474 (St. Francis Hospital) v. NLRB*, 814 F.2d 697 (D.C. Cir., 1987) to the effect that varying expressions of Congressional intent are not legally binding upon the Board’s since the statutory language was not changed.

We are inclined to agree with Judge Edwards that, since section 9(a) was not changed in 1974, varying expressions by legislators on what they intended do not

necessarily rise to a mandate requiring, for example, a disparity of interests standard.⁸ Contrary to the understanding of The American Society for Personnel Administration, Comment 1686, it is not true that "with the limited exception of the construction industry, virtually no other industry covered by the NLRA must cope with as many as eight bargaining units." In industrial settings, there is the potential for far more than eight appropriate bargaining units. The following are but a representative sampling of the separate bargaining units found appropriate by the Board in various cases:

1. Drivers⁹
2. P & M (production and maintenance) employees¹⁰
3. Office clericals¹¹
4. Guards¹²
5. Technical employees¹³

⁸ Accord: Kilgour. The Health-Care Bargaining Unit Controversy: Community of Interest versus Disparity of Interest, 40 Lab. L.J. 81 at 92 (1989). See also *The D.C. Circuit Struggles With Standards of Reviewability*, 56 Geo. Wash. L. Rev. 960 (1988).

⁹ *Memphis Furniture Manufacturing Co.*, 259 NLRB 401 (1961).

¹⁰ *Comet Corp.*, 261 NLRB 1414 (1962).

¹¹ *Robbins & Myers*, 144 NLRB 295 (1963).

¹² *Bonded Armored Carrier*, 195 NLRB 346 (1972).

¹³ *Local Corp.*, 200 NLRB 1019 (1972).

6. Driver-salesmen¹⁴
7. Toolroom employees¹⁵
8. Maintenance department employees¹⁶
9. Warehouse and service employees¹⁷
10. Patternmakers¹⁸
11. Electricians¹⁹
12. Welders²⁰
13. Tool designers²¹
14. Crane operators²²
15. Powerhouse employees²³
16. Millwrights²⁴
17. Attorneys²⁵

¹⁴ *Bardahl Oil Co.*, 163 NLRB 260 (1967).

¹⁵ *McCulloch Corp.*, 189 NLRB 76 (1971).

¹⁶ *Verona Dyestuff Div.*, 225 NLRB 1159 (1976).

¹⁷ *A.B. Dick Co.*, 230 NLRB 257 (1977).

¹⁸ *Mueller Industries*, 132 NLRB 469 (1961).

¹⁹ *E.I. DuPont de Nemours and Co.*, 192 NLRB 1019 (1971).

²⁰ *Aerojet General Corp.*, 128 NLRB 313 (1960).

²¹ *Douglas Aircraft Co.*, 157 NLRB 791 (1966).

²² *Louisiana Industries*, 15-RC-2441, cited at 49 LRRM 1414 (1961).

²³ *American Can Co.*, 131 NLRB 909 (1961).

²⁴ *National Container Corp.*, 99 NLRB 1492 (1952).

²⁵ See *Westinghouse Air Brake Co.*, 121 NLRB 636 (1958). Cf. *Legal Action of Wisconsin*, 261 NLRB 1095 (1985).

18. First-aid department employees²⁶
19. Chemists, chemical engineers, and engineers²⁷
20. Garment cutters and spreaders²⁸
21. Industrial art designers²⁹
22. Knitters³⁰
23. Auto mechanics³¹

These twenty-three (there are at least as many more) potential units are, of course, unlikely to arise in any single establishment, just as it is unlikely that all eight potential appropriate units will occur in any given hospital³². In fact, based on our experience following the

²⁶ *Ladish Co.*, 178 NLRB 90 (1969). And see *Westinghouse Air Brake Co.*, *supra* (nurses).

²⁷ *Firestone Tire & Rubber Co.*, 181 NLRB 830 (1970). See also *Westinghouse Air Brake*, *supra*.

²⁸ *Benjamin & Jones*, 133 NLRB 768 (1961).

²⁹ *Chrysler Corp.*, 90 NLRB No. 265 (1950), not reported in Board volumes; reported at 26 LRRM 1415 (1950).

³⁰ *Morganton Full Fashioned Hosiery Co.*, 115 NLRB 1267 (1956).

³¹ *Dodge City of Wauwatosa*, 282 NLRB No. 71 (1986).

³² In Comment 1142, Bricker & Eckler alleges that attorney Roger King's testimony concerning other-professional units was taken out of context. It is alleged that King intended only to show that there was very little organizing among RNs in Ohio: i.e., such units exist in only 16 of Ohio's 180 private hospitals. However, King also testified that, in Ohio, only one separate other-professional unit exists (NPR II at 33908). We believe that King's testimony does support the conclusion for which it was cited, that in Ohio, the existence of separate units of RNs has not led to similar, separate units of all other professionals.

1974 health care amendments, we anticipate that most of the organizing will occur in RN units, technical units, skilled maintenance units, service and unskilled maintenance units, and, possibly, business office clerical units. Many physicians in hospitals are independent contractors, and there have been only one or two published cases involving separate physicians' units since 1974 (NPR, 52 FR 25147; NPR II, 53 FR 33905). Although a separate guard unit is mandated by the Act, we have had few if any hospital guard unit cases, perhaps because some hospitals contract out their guard service. The unit of all other professionals is also required by the Act, if, as we have found, RNs and physicians constitute separate appropriate units; however, we have not had a large number of other professional units.

The original rulemaking record provided strong empirical support for all the units ultimately proposed in NPR II. In addition to the other factors mentioned in NPR II in support of the individual units, the separate labor markets for the RNs, skilled maintenance employees, and business office clericals favored separate representation for them. The legislative history showed "proliferation" was opposed by Congress because it was feared that would lead to numerous work stoppages, jurisdictional disputes, and wage whipsawing and leapfrogging. However, as was amply documented in NPR II, multiple units have not been shown to cause an unusual number of work stoppages, nor have they been shown to have caused jurisdictional disputes, wage whipsawing, or leapfrogging. Little additional evidence on these points was introduced during the current round of comments, except that several commenters expressed the view that,

since there have never, or rarely, been eight bargaining units in the health care field, the Board's evidence as to costs, strikes, bargaining success, and unionization is irrelevant. (See, e.g., Comment 1711, AHA; Comment 1081, Wausau Hospital. See also Comment 1044, Missouri Hospital Association, which argues that early units were recognized voluntarily because, prior to 1974, it was known that individual units could not strike.)

We do not agree that the evidence acquired during this proceeding is irrelevant. For one thing, even under adjudication, whether strikes, whipsawing, or jurisdictional disputes will result if an initial organizational effort succeeds carries with it a greater degree of speculativeness than is alleged here; under adjudication of individual cases, no evidence whatever can be adduced as to the facility under consideration, whereas, at least here, past experience in the industry generally can be and has been considered. The fact is that in the decade between 1974 and 1984 there were, generally, eight units recognized as appropriate under Board case law (including the statutorily-mandated separate unit of guards.) Despite continual uncertainty as to the proper standard, there was considerable organizational activity, and the evidence presented to us is that there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.

Comment 725, Greater Baltimore Medical Center, argues that, where there are existing units, more than eight may ultimately be found appropriate. While that is a theoretical possibility because section 103.30(c) of the rule technically removes such facilities from the literal reach of the rule, section XV of NPR II refers to the

principle of *Levine Hospital of Hayward*, 219 NLRB 327 (1975), which in effect prohibits residual or fractional units in health care facilities. The Board in NPR II deferred this issue to adjudication. Our stated intention will be, insofar as possible, to conform new units in such situations to the proposed rule.

As for the question whether the units found appropriate are too many, or proliferative, we do not believe that that was a question Congress wished us to answer in the abstract – as if, for example, “x” number of units are automatically proliferative, but “y” are not. Rather, we believe it has been incumbent upon us to carefully examine the exhaustive rulemaking record furnished by numerous parties from all sectors of the health care industry, and then to make a determination on appropriate units consistent with that evidence, consistent with our self-expressed desire to avoid a proliferation of units, and consistent with a requirement that these units not be likely to produce the unwanted results of repeated work stoppages, jurisdictional disputes, wage whipsawing, and other related evils. We believe we have done so and, for that reason, conclude that our determination is not unduly or reasonably proliferative in any meaningful usage of that phrase.³³

³³ We note that our unit determinations in this proceeding are not inconsistent with those in the cases cited with approval in the Senate Committee Report (S. Rept. 93-766, 93d Cong., 2d sess. 5 (1974)). Thus, in *Four Seasons Nursing Center of Joliet*, 208 NLRB 403 (1974), the Board found inappropriate a three-employee unskilled maintenance unit in a nursing home. Our rule does not cover nursing homes, and three-employee units are considered an “extraordinary circumstance” even in acute

(Continued on following page)

Our action in exempting units of five or fewer employees from the coverage of the rule is prompted by our concern about proliferation. Comments about the effects of a number of small units in small hospitals convince us that they could pose a serious proliferation potential. It is for that reason that we have excepted these small units from coverage of the rule. We note that the "small unit" exception is not limited to small hospitals. It could also have the effect of reducing the number of units in large health care institutions.

In addition to the foregoing, we continue to believe that Congress was concerned with the Board's not repeating the pattern of bargaining in such industries as newspapers and construction, and affirm those additional portions of NPR II which discuss this point.

(Continued from previous page)

care hospitals. In addition, maintenance employees who primarily empty trash, replace light bulbs, and move furniture are included in service units. In *Woodland Park Hospital*, 205 NLRB 888 (1973), the Board declined to find appropriate a separate unit of x-ray technicians. Our rule would, likewise, find inappropriate a separate unit of x-ray technicians. (The Board in *Woodland* did not have occasion to consider the appropriateness of an all-technical unit, since no request for review was filed to the regional director's ruling on that issue.) Finally, in *Extendicare of West Virginia, Inc., d/b/a St. Luke's Hospital*, 203 NLRB 1232 (1973), the Board found appropriate a separate unit of licensed practical nurses, but included the seven remaining technicals with the service and maintenance employees. Our rule would not find appropriate a separate unit of licensed practical nurses, who in prior Board cases have been found to be technical employees, but would rather group all technical employees together in a separate unit.

XIV. Regulatory Flexibility Act

No comments after NPR II addressed this issue. We reaffirm our prior certification. (53 FR 33934)

XV. Dissenting Opinion

Member Wilford W. Johansen dissents from establishing health care bargaining units through a rulemaking procedure.

In his view rulemaking in the health care industry is neither appropriate nor desirable, for several reasons.

He believes the language of the Act itself forecloses rulemaking for particular units. Section 9(b) of the Act requires that "The Board *shall* decide in each case" what the appropriate unit shall be, "in order to assure to employees the fullest freedom in exercising the rights guaranteed by" the Act. Under basic rules of statutory construction, he reads that language as mandatory rather than permissive. He also believes that the Board cannot satisfactorily fulfill its statutory obligation by relegating that specialized, decisional function to rulemaking procedures. Thus, while rulemaking is a desirable and even a necessary portion of the Board's functions in some areas, in his opinion, this is not one of those areas. It is important to remember that Congress did *not* amend section 9 when it enacted the Health Care Amendments in 1974. If Congress had intended that the Board abandon its then almost 40-year old decisional approach and instead embark on a wholly new procedure for determining appropriate units in portions of the health care industry (and only in that industry) it surely would have said so

explicitly. It did not do so; nor did it even implicitly suggest such action. The Board "rules" referred to by the majority as grounds for this action (i.e., *Excelsior* list, contract, bar, etc.) in his view simply do not support such a radical departure from well established precedent. They were themselves arrived at decisionally, and they did not involve unit determinations. Nor is he persuaded by reference to interpretation of different functions by other agencies.

Even assuming that abandoning the Board's decisional format for determining the appropriate unit in each case is a permissible exercise, however, he would not deem rulemaking with regard to health care units to be either necessary or desirable.

The disagreements between members of the Board or between one Board majority and another, have focused on questions concerning the meaning of the statute, analysis of the legislative history, and the interpretation of Congress' intent. The differences between the Board and various courts of appeals and the conflicts among the courts of appeals have involved not only those questions which divided the Board, but also issues concerning the proper scope of review, and the deference to be properly accorded to the Board's reading and interpretation of the Act - the Board's primary function and responsibility.

The appropriate procedure to resolve questions surrounding Congress' intent, the proper scope of review, and the Board's duty and authority in the exercise of its expertise under the statute, is to submit those questions to the Supreme Court, the final arbiter on issues of this nature. That is particularly true in this area, because the

Board has received criticism from Circuit Courts at both ends of the spectrum. Most of the disagreement has centered around application of the traditional "community of interest" standard versus a separate "disparity of interest" test for evaluating appropriate units in health care facilities. Different courts at different times have rejected each of these approaches. Thus, it seems especially appropriate to submit these issues to the Supreme Court to resolve the split in the circuit. That process best serves the interests of the parties, the general public, and the Board.

Other factors make the establishment of particular health care units through rulemaking at best inadvisable. Those courts that have deemed the Board's approach to health care units to be too rigid will continue to criticize such units established through rulemaking. And, because unit determinations established by a predetermined set of rules are inherently less flexible than those arrived at by decision in specific cases, it must be anticipated that criticism by some courts will intensify; on the ground that a result reached by the Board was not derived through application of its institutional expertise in a particular factual situation. Indeed, the Board must concede the validity of at least some such criticism. That is so not only because the rules themselves are less flexible, but also because the nature of the evidence on which the rule is based is in turn more generalized - primarily anecdotal and statistical - and, therefore, lacks the quality of pertinent evidence regarding a specific situation which lies at the core of the decisional process.

Another reason to reject the rule is the information which the Board has obtained during this process. As a

result of that experience, the Board has already seen fit to revise the proposed rules substantially. That fact in itself is a compelling reason to retain the Board's traditional decisional format, even if it were not required.

There have been considerable changes from one year to the next in this proceeding. Nursing homes and rehabilitation hospitals have been exempted from operation of the rule. The proposed "100-bed" distinction has been eliminated, along with the separate unit configuration for small hospitals. Thus, the number of proposed units affecting small hospitals has changed dramatically; and the number of units in large (now all) acute hospitals has been expanded by the addition of separate groupings for maintenance, and business office clerical employees. We do not know what will happen next year. Will the heavy burden of proof required under the "extraordinary circumstances" proviso virtually preclude evidence that the units established in this proceeding make little practical sense in a particular case? Will the Board need to indicate - again - that it might have proceeded differently if there had been more, or better, information when the rule was made? And, in that case, will the Board, the parties, and the public have to undergo another two year exercise in order to amend the rule to accord with what the Board then knows (or believes it "knows")? Such uncertainties neither benefit the Board nor any other constituency. Certainly they do not effectuate the purposes of the Act.

For all these reasons, Member Johansen would vacate the notices of rulemaking and submit the issues to the Supreme Court for resolution.

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

Regulatory Text

For the reasons set forth at 52 FR 25142-25145 (through Section IV), and also 53 FR 33900-33934, as supplemented and modified by this Supplementary Information, 29 CFR Part 103 is amended as follows:

PART 103 - OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 156, in accordance with the procedure set forth in 5 U.S.C. 553.

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C - Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to

section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:

- (1) All registered nurses.
 - (2) All physicians.
 - (3) All professionals except for registered nurses and physicians.
 - (4) All technical employees.
 - (5) All skilled maintenance employees.
 - (6) All business office clerical employees.
 - (7) All guards.
 - (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. *Provided That* a unit of five or fewer employees shall constitute an extraordinary circumstance.
- (b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.
- (c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to sec. 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section.
- (d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of

this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after May 22, 1989.

(f) For purposes of this rule, the term:

(1) "Hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(e), as revised 1988);

(2) "Acute care hospital" is defined as: either a short term care hospital in which the average length of a patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals. Where, after issuance of a subpoena, an employer does not produce records sufficient for the Board to determine the facts, the Board may presume the employer is an acute care hospital.

(3) "Psychiatric hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(f)).

(4) The term "rehabilitation hospital" includes and is limited to all hospitals accredited as such by either Joint ~~Committee~~ on Accreditation of Healthcare Organizations or by Commission for Accreditation of Rehabilitation Facilities.

(5) A "non-conforming unit" is defined as a unit other than those described in paragraphs (a)(1) through (8) of this section or a combination among those eight units.

(g) Appropriate units in all other health care facilities: The Board will determine appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, by adjudication.

Dated, Washington, DC, April 18, 1989.

John C. Truesdale,
Executive Secretary.

[FR Doc. 89-9654 Filed 4-20-89; 8:45 am]

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(11)
No. 90 - 97

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United States
Court Of Appeals For The Seventh Circuit

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

The Health Care Amendments Act of 1974 repealed the exemption of most hospitals from the National Labor Relations Act. In taking that action, Congress admonished the National Labor Relations Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." Pet. App. 8a. Ever since, the Board's attempts to apply to the health care industry the same bargaining unit standards it applies in other industries have met with failure. The courts of appeals have rejected the Board's determinations, usually on the ground that they failed to give proper weight to the congressional admonition against proliferation. Responding to this "dismal background" (*id.* at 15a), in 1987 the Board for the first time in its history decided to engage in formal, substantive rulemaking. The rule it issued provides that eight specific bargaining units (and only those units) are appropriate for every acute-care hospital in the country. The questions presented are:

1. Whether the National Labor Relations Board's rule determining that eight specific bargaining units are appropriate for every acute-care hospital contravenes the requirement of Section 9(b) of the National Labor Relations Act (29 U.S.C. § 159(b)) that "[t]he Board shall decide [the appropriate bargaining unit] in each case."
2. Whether the rule is consistent with the Health Care Amendments Act of 1974 and the congressional admonition to "prevent[] proliferation of bargaining units in the health care industry."
3. Whether the rule is arbitrary and capricious and not based on substantial evidence insofar as it ignores the critical differences among the more than 4,000 private, acute-care hospitals in the United States.

PARTIES TO THE PROCEEDINGS AND RULE 29.1 STATEMENT

In addition to the parties named in the caption, the following entities and individuals were appellants in the court of appeals and are respondents in this Court:

James M. Stephens
Mary Miller Cracraft
Dennis M. Devaney
Clifford R. Oviatt, Jr.*
John N. Raudabaugh*
John C. Truesdale
American Nurses Association
American Federation of Labor and Congress
of Industrial Organization
Building and Construction Trades
Department, AFL-CIO

* Substituted as a respondent pursuant to Rule 35.3 of the Rules of this Court. Former Board Member John E. Higgins, Jr., was an appellant in the court of appeals.

Pursuant to Rule 29.1 of the Rules of this Court, petitioner American Hospital Association states that it has no parent or subsidiary companies (other than wholly-owned subsidiaries).

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-16a) is reported at 899 F.2d 651. The opinion of the district court (Pet. App. 17a-42a) is reported at 718 F. Supp. 704.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1990. The petition for a writ of certiorari was filed on July 10, 1990, and was granted on October 9, 1990. The jurisdiction of the Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), and the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-16348 (1989), 29 C.F.R. § 103.30, are set forth at Pet. App. 43a-46a. The Board's Notice of Proposed Rulemaking, 52 Fed. Reg. 25142 (July 2, 1987), Second Notice of Proposed Rulemaking, 53 Fed. Reg. 33900 (Sept. 1, 1988) and Final Rule are set forth at J.A. 3-262.

STATEMENT

From 1947 until 1974, most hospitals were excluded from the coverage of the National Labor Relations Act.¹ When Congress amended the law in 1974 to encompass all pri-

¹ Before 1974, the Act excluded nonproprietary (i.e., private, not-for-profit) hospitals. They comprise nearly 83% of all private hospitals. American Hospital Ass'n, *Hospital Statistics* 207 (1989-90 ed.). Public employers, including hospitals, remain excluded from the Act. 29 U.S.C. § 152(2).

vate hospitals, it specifically instructed the National Labor Relations Board that in carrying out its statutory obligation to "decide in each case" the appropriate unit for collective bargaining, it should give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). From 1974 until 1987, the Board's hospital bargaining unit determinations repeatedly were rejected by the courts of appeals, usually on the ground that the Board had ignored the congressional admonition against proliferation of bargaining units.

Clearly frustrated by its failure in the courts (Pet. App. 15a), in 1987 the Board engaged in "the first significant substantive exertion of [its] rulemaking powers." *Id.* at 1a. The rule it ultimately issued provides that eight specific bargaining units are the only appropriate units for all acute-care hospitals regardless of their size, location, or differences in their staffing and operation. Petitioner American Hospital Association ("AHA") successfully challenged the bargaining unit rule in the district court, which held that the Board once again had failed to follow the congressional admonition. But the court of appeals—following an approach that differed markedly from that of other courts of appeals in health care bargaining unit cases—reversed and upheld the rule.

This Court granted AHA's petition for certiorari to determine whether the Board's rule is consistent with the "in each case" requirement of Section 9(b) of the NLRA and with the congressional admonition against bargaining-unit proliferation, and to decide whether, by disregarding the many differences among hospitals, the Board's rigid bargaining-unit rule is arbitrary and capricious.

1. The National Labor Relations Act authorizes "[r]epresentatives designated or selected * * * by the major-

ity of the employees in a unit appropriate for such purposes" to serve as "the exclusive representatives of all the employees in such unit for the purposes of collective bargaining * * *." 29 U.S.C. § 159(a). The Act expressly provides that the question of what unit is "appropriate for such purposes" must be decided by the National Labor Relations Board "in each case":

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.

Ibid.

As originally enacted in 1935, the Act covered all private hospitals. But in 1947, as part of the Taft-Hartley Act, Congress amended the definition of "employer" to exclude "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." 29 U.S.C. § 152(2) (repealed, 1974). The exclusion was seen by its sponsors as necessary to "enable [nonprofit institutions] to keep the doors open and operate the hospitals." NLRB, *Legislative History of the Labor Management Relations Act, 1947*, at 1464 (Reprint ed. 1985).

The Health Care Amendments Act of 1974 repealed the exemption of nonproprietary hospitals.² That Act was the product of a legislative process that lasted two years. In

² In 1967, the Board reversed its previous position that private, proprietary hospitals were not engaged in interstate commerce and therefore were not covered by the Act. *Butte Medical Properties*, 168 NLRB 266, 268 (1967); *University Nursing Home, Inc.*, 168 NLRB 263 (1967). But because more than 80% of private hospitals are nonproprietary (see American Hospital Ass'n, *Hospital Statistics* 20), that ruling did not lead to much organizing activity among hospital employees.

1972, a House bill that simply would have repealed the hospital exemption failed to make it out of committee in the Senate. Among the Senate opponents of the bill was Senator Robert Taft, Jr. Unlike other opponents of the bill, Senator Taft did not object to extending collective bargaining rights to hospital employees, but believed that the industry warranted special protection "to minimize work stoppages and to insure safe patient care." *Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare*, 93d Cong., 1st Sess. 75 (1973) (hereinafter "1973 Hearings").

In 1973, Senator Taft sponsored a new bill (S. 2292) that would have designated four bargaining units as appropriate in all health care institutions: professionals, technicians, office clericals, and other nonprofessionals (i.e., service and maintenance employees). *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974* (hereinafter referred to as "1974 Leg. Hist."), at 457-458. Under the bill, the Board could not approve narrower units without the consent of the employer. *Ibid.* But Senator Taft's bill was opposed as overly rigid and unduly restrictive of the flexibility of the Board to determine health care bargaining units on a case-by-case basis taking into account the particular situation at each hospital. *Id.* at 113-114.³

In light of these objections, Senator Taft sponsored a compromise bill that became the Health Care Amendments Act of 1974. *1974 Leg. Hist.* at 462. The bill did not limit the Board's prescribed flexibility to determine the appro-

³ The Administration took the position that neither the simple repeal of the hospital exemption nor Senator Taft's four-unit bill was appropriate. Instead, it urged Congress to extend NLRA coverage to hospitals under existing Board procedures but with "some additional safeguards" for the industry. *1973 Hearings* at 434, 436 (statement of Undersecretary of Labor Richard F. Schubert).

priate bargaining unit "in each case," but the sponsors agreed that the following language should appear in both the Senate and the House Reports (S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974)):

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).*

* By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

That agreed-upon language in the legislative history has become known as the "congressional admonition." The admonition expressed Congress's intent not only that the Board give consideration to avoiding a proliferation of units that would burden hospitals and threaten patient care, but also "that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis." *St. Francis Hospital*, 271 NLRB 948, 951 n.17 (1984), remanded, *International Brotherhood of Electrical Workers v. NLRB*, 814 F. 2d 697 (D.C. Cir. 1987).

2. Following passage of the 1974 Act, the National Labor Relations Board determined the appropriateness of hospital bargaining units in its traditional way: through case-by-case adjudication. But as the court below found—and as the Board acknowledged in its first Notice of Proposed Rulemaking ("NPR I"), J.A. 5-9—the Board's efforts were "widely regarded as a failure" (Pet. App. 15a) and were regularly rejected by the courts of appeals, usually on the ground that the Board had failed to pay proper heed to the congressional admonition. It was against this

"dismal background" (*ibid.*) that the Board decided to abandon the flexible, case-by-case approach that had been applauded by the opponents of Senator Taft's first bill and to adopt its own rigid rule.

In *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975), the Board first considered a hospital bargaining unit in the light of the congressional admonition. The regional director of the Board had determined that a unit of all professionals—rather than the requested unit of registered nurses only—was appropriate. The full Board disagreed, however, and held "that registered nurses * * * are entitled to be represented for the purposes of collective bargaining in a separate bargaining unit." *Id.* at 767. But when the Board subsequently attempted to apply this *per se* rule that registered nurses were entitled to a separate unit, the Ninth Circuit denied enforcement. *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979).

The Ninth Circuit carefully considered the legislative history of the 1974 Act, including the congressional admonition, and held that although a unit of registered nurses might be appropriate in some cases, the Board could not establish a presumption that such units are appropriate and thus dispense with the required case-by-case consideration (601 F.2d at 416):

This is not to say that a determination of a bargaining unit composed exclusively of registered nurses can never be valid. Rather, the problem lies in a rule that such a unit is always valid and its concomitant procedural quirk which excludes any consideration of evidence to the contrary. What is necessary is a demonstration, not a mere presumption, of a disparity of interests between registered nurses and other hospital employees.

Several other courts of appeals also rejected bargaining unit determinations when the Board attempted to ap-

ply presumptions that certain bargaining units were appropriate or otherwise failed to consider in each case whether the proposed unit would cause "proliferation." See, e.g., *Long Island Jewish-Hillside Medical Center v. NLRB*, 685 F.2d 29, 34-35 (2d Cir. 1982) (presumption that separate units should be recognized in each of an employer's facilities is inappropriate in the health care context in light of the congressional admonition); *NLRB v. Mercy Hospital Ass'n*, 606 F.2d 22, 27-28 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980) (maintenance unit rejected because Board failed to conduct "an independent evaluation" of whether it would contribute to proliferation "in this particular hospital"); *St. Vincent's Hospital v. NLRB*, 567 F.2d 588, 592-593 (3d Cir. 1977) (certification of separate unit of licensed boiler operators failed to heed the admonition); *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (separate unit of registered nurses requires specific explanation of how the unit comports with the admonition); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 216 (7th Cir. 1978) (Board failed to show how "its unit determination in this case implemented or reflected th[e] admonition"); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 809-812 (9th Cir. 1982) (Kennedy, J.) (Board improperly certified separate unit of registered nurses without evaluating whether unit would lead to proliferation; Board has "ignored a controlling legal standard" and has "openly adopt[ed] a posture of noncompliance with the will of Congress"); *Beth Israel Hospital & Geriatric Center v. NLRB*, 688 F.2d 697, 698-699 (10th Cir. 1982), cert. dismissed, 459 U.S. 1025 (1982) (admonition precludes use of presumption that a bargaining unit is appropriate; Board must find in each case that the "units will not lead to undue proliferation at [the particular] health care facilities"); *Presbyterian/St. Lukes Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981), cert. dismissed, 459

U.S. 1025 (1982) (reliance on presumption that a unit of registered nurses is appropriate violates the admonition).⁴

3. The Board's dismal record in the courts of appeals led it to revive its long-dormant rulemaking powers. Finding that "[t]hirteen years and many hundreds of cases later, the Board * * * [is] no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974" (NPR I, J.A. 9), the Board concluded that it could achieve greater "judicial and public acceptance" (*id.* at 14) of its approach to hospital bargaining units if it engaged in rulemaking to determine in advance what units were appropriate. The Board proceeded not merely to establish general guidelines, but to issue a rigid rule that eight designated bargaining units (and only those eight units) would be appropriate for every acute-care hospital, regardless of differences in size and operation. "We have decided not to make the units only 'presumptively' appropriate, because one important advantage of rulemaking is the certainty it offers." *Id.* at 21.

Although the original Notice of Proposed Rulemaking distinguished between large and small facilities and provided for only six bargaining units in large hospitals and four units in small hospitals (NPR I, J.A. 37-38), the

⁴ In 1984, the Board reconsidered its approach to hospital bargaining units. In *St. Francis Hospital*, 271 NLRB at 953-954, it issued a new rule based on a "disparity of interests" standard that, in the words of the Board's Chairman, "as a practical matter allows for only four units—professionals, technicals, other nonprofessionals and guards." Stephens, "The NLRB's Health Care Rulemaking: Myths versus Reality," reprinted in N. Metzger, ed., *Handbook of Health Care Human Resources Management* 405, 409 (2d ed. 1990). However, the new rule was rejected by the District of Columbia Circuit, which held (against the weight of the circuits) that the Board erred in giving effect to the congressional admonition. *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697, 714-715 (D.C. Cir. 1987). That decision was "the straw that broke the camel's back and prompted us to undertake rulemaking." Stephens, *supra*, at 409. See also NPR I, J.A. 6-9.

Board's final rule eliminates the distinction based on size and increases the number of units to eight, providing that "[e]xcept in extraordinary circumstances," the following eight "shall be appropriate units, and the only appropriate units" for acute-care hospitals (Final Rule, J.A. 259-260):

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All [other] nonprofessional employees * * *.

The Board made it quite clear that the "extraordinary circumstances" exception was to be extremely narrow. The Board put hospital employers on notice that it would not consider additional evidence or arguments that a particular hospital varied from the norm even if the variation is "highly unusual." Second Notice of Proposed Rulemaking ("NPR II"), J.A. 187. "To satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate * * * the existence of * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field." *Id.* at 189-190. The Board specified a long list of factors that it would not even consider as possible extraordinary circumstances.⁵

⁵ NPR II, J.A. 188. The list includes: "(1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result

(Footnote continued on following page)

4. Petitioner American Hospital Association filed suit challenging the rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court held that the rule was invalid and issued a permanent injunction barring its enforcement. Pet. App. 42a. The court "left for another day" (*id.* at 36a) the question of whether the Board's rule was precluded by the requirement of Section 9(b) that it determine the appropriate bargaining unit "in each case." 29 U.S.C. § 159(b). But it held that "[a] rule which designates an absolute number of appropriate units and mandates a particular division of the workforce * * * encourages, and perhaps coerces, fragmentation of the labor force" and therefore contravenes the congressional admonition. Pet. App. 41a-42a. The court thus found it unnecessary to reach AHA's claim that the rule was arbitrary, capricious, and not supported by substantial evidence.

The court of appeals reversed. Citing this Court's decision in *Heckler v. Campbell*, 451 U.S. 458, 467-468 (1983), the court of appeals held that the "in each case" requirement of Section 9(b) did not require case-by-case determination of bargaining units. The court also held that the rule was not precluded by the congressional admonition. Although it found that the admonition was entitled to "consideration," the court held that Congress was concerned with "finer divisions of the health-care work force than attempted in the rule under challenge." Pet. App. 14a.

The court of appeals also considered and rejected AHA's claim that the rule was arbitrary and capricious, particular-

⁵ continued

of the advent of the multi-competent worker, increased use of 'team' care, and cross-training of employees; (3) the impact of nation-wide hospital 'chains'; (4) recent changes within traditional employee groupings and professions, e.g. the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building."

ly insofar as it failed to distinguish between "hospitals of different sizes and missions in different locations." Pet. App. 14a. Although the court found the hospital industry's argument that it was inappropriate for the Board to treat all hospitals alike to be "an important criticism," it chided the industry for failing to propose alternatives to the rule, not "respond[ing] constructively" to the Board's proposal of a six-employee minimum size for bargaining units, and "opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." *Ibid.* Without discussing any of the evidence in the record—and even though the district court had not reached the issue and therefore had not reviewed the evidence—the court of appeals held that the rule was not arbitrary. *Id.* at 14a-16a.

On May 2, 1990, the court of appeals granted AHA's motion to stay the issuance of the mandate pending review by this Court. This Court granted the petition for a writ of certiorari on October 9, 1990.

SUMMARY OF ARGUMENT

I.

The Board's rule designating eight specific bargaining units as the only appropriate units for acute-care hospitals violates the requirement of Section 9(b) of the NLRA that the Board determine the appropriate bargaining unit "in each case." The "in each case" language was deliberately added to the Act to make it clear that Congress wanted the Board to engage in case-by-case determinations of bargaining units. It reflected the experience of the predecessor labor boards that the appropriate bargaining unit depended upon the facts of the particular case and that it would be unwise to attempt to establish rigid rules designating particular units as appropriate in every case. Therefore over the years, the Board and the courts have acknowledged the need for case-by-case unit determinations.

The Board's rule clearly violates the requirement of case-by-case determination of bargaining units. It precludes any meaningful consideration of the facts of a particular case. The Board has not merely established rules of general applicability to guide the unit determination process. Instead, it has established conclusive presumptions of law that apply even when the facts would warrant a different result.

None of the reasons given by the court of appeals for disregarding the "in each case" language can withstand analysis. The Board's rule in this case is not analogous to the Social Security Administration's rule upheld in *Heckler v. Campbell*, 461 U.S. 458 (1983). The statute involved in that case did not require determinations "in each case," and this Court made it clear that issues of fact unique to each case must be determined on a case-by-case basis. Section 9(b) cannot be explained as merely dealing with an old dispute between craft and industrial unionists. But even if it could, the "in each case" requirement was enacted into law and still stands, and cannot be ignored by the Board. The language of the statute and its legislative history do not deal solely with the allocation of responsibility to the Board to determine the appropriate unit, but instead make it clear that the Board must carry out its responsibility on a case-by-case basis.

II.

The health care bargaining unit rule is also contrary to the congressional admonition requiring the Board to take due care to avoid "proliferation of bargaining units in the health care industry." The admonition was included in both the Senate and House reports that accompanied the 1974 statute that extended the coverage of the NLRA to include the hospital industry. The admonition confirms that Section 9(b) requires individual, case-by-case determination of bargaining units.

The admonition is also of independent significance as evidence of the intent of Congress when it amended the entire NLRA to cover the health care industry. The legislative history—including the congressional admonition—demonstrates that Congress expected the Board to consider in each case whether approval of the unit requested would result in or lead to a proliferation of bargaining units.

III.

Insofar as it ignores the many critical differences among acute-care hospitals, the Board's rule is arbitrary, capricious, and not supported by substantial evidence. As the Board and its Regional Directors have found in numerous cases over the years, the diverse nature of the hospital industry precludes the application of any rigid rule that particular bargaining units are appropriate in every case. The Board's decision to treat all hospitals as if they were alike represents an abrupt reversal of positions and cannot stand without more thorough analysis than that provided by either the Board or the court of appeals.

ARGUMENT

THE NLRB'S HOSPITAL BARGAINING UNIT RULE IS INVALID BECAUSE IT CONFLICTS WITH THE LANGUAGE AND LEGISLATIVE HISTORY OF THE NLRA AND IGNORES CRITICAL DISTINCTIONS AMONG THE NATION'S 4,000 COVERED HOSPITALS

I. The Board's Rule Designating Eight Specific Bargaining Units As The Only Appropriate Units For Acute-Care Hospitals Is Contrary To The Requirement Of Section 9(b) That The Board Determine The Appropriate Unit "In Each Case."

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), requires the Board to determine an appropriate bargaining unit "in each case":

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.

As Member Wilford W. Johansen observed in his dissent to the Board's rulemaking (J.A. 201), the bargaining-unit rule at issue here violates the plain meaning of Section 9(b) and represents a "radical departure from 50 years of Board precedent."

A. The Language And Legislative History Of Section 9(b) Demonstrate That Individual, Case-By-Case Determination Of Bargaining Unit Appropriateness Is Required

In its rulemaking proceedings, the Board attempted to characterize the "in each case" requirement of Section 9(b) as essentially meaningless, added to the Act as a "small amendment[] * * * for the sake of clarity." Final Rule, J.A. 212. We agree that the "in each case" language was added "for the sake of clarity"—to make it clear that Congress wanted the Board to engage in individual, case-by-case determinations of bargaining units and not to apply rigid, across-the-board categorizations.

1. In the original version of the National Labor Relations Act proposed by Senator Robert Wagner, Section 9(b) contained all of the present language *except* the words "in each case." Those words were added quite deliberately, by an amendment proposed by Secretary of Labor Frances Perkins, and were intended to carry their plain meaning. The House Report that accompanied the version of the bill that added the "in each case" language explained that the decision of whether a bargaining unit is appropriate "is obviously one for determination in each individual case * * *." H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935), reprinted in NLRB, *Legislative History of*

the National Labor Relations Act 1935 ("1935 Leg. Hist.") at 2930 (Reprint ed. 1985) (emphasis added). The same explanation of the language also appears in H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935), reprinted in *1935 Leg. Hist.* at 2976; and H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935), reprinted in *1935 Leg. Hist.* at 3072.

In proposing the "small amendment" to make it clear that bargaining unit questions needed to be decided on an individual, case-by-case basis, the Secretary of Labor was well aware of the experience of the National Labor Board (1933-1934) and of the first National Labor Relations Board, created by Executive Order in 1934. Those Boards, operating under Section 7(a) of the National Industrial Recovery Act, established the principles of exclusive representation and majority rule. They struggled over bargaining unit questions and in the end concluded that no set rules were appropriate and that bargaining units should be determined based on the facts of each case.

As the first NLRB put it, "the question of what industrial unit should be recognized * * * is peculiarly an administrative matter which has been determined flexibly by the Board * * * without laying down too rigid general principles." *NLRB Six-Month Report to the President*, quoted in J. Gross, *The Making Of The National Labor Relations Board* 98 n.95 (1974). Francis Biddle, Chairman of the first NLRB, testified in support of the new law as follows:

It is impossible, however, to lay down a definite rule for the determination of the appropriate unit, for such an attempt would result in rigidity and confusion. The whole system of industrial control and development depends on flexibility, and such considerations must be taken into account as the question of management and supervision, routine employment contracts, existing plans of collective bargaining, and the distinctiveness of the occupation.

1935 Leg. Hist. at 1459. See also *Houde Engineering Corp.*, 1 *Decisions Of The [First] National Labor Relations Board* 35, 44 (1934) ("This opinion lays down no rule as to what should constitute the proper unit as the basis of representation. * * * The question of the proper unit or units must be left for determination according to the circumstances of particular cases as they arise."); I. Bernstein, *The New Deal Collective Bargaining Policy* 86 (1950).

2. From the outset, the present National Labor Relations Board acknowledged that the Act required individual, case-by-case bargaining unit determinations. The Board's very first annual report explained that Congress required the Board to determine the appropriate unit individually in each particular case and precluded the adoption of rigid rules:

Experience has proven the wisdom of delegating to the Board the task of deciding in each case the unit appropriate for purposes of collective bargaining. The complexity of modern industry, transportation, and communication, and the numerous and diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case.

NLRB, *First Annual Report* 112 (1936). Of course, this contemporaneous interpretation of the statute by the Board in its first year under the Act is entitled to great weight. *EEOC v. Associated Dry Goods Corp.*, 449 U.S. 590, 600 n.17 (1981); *Power Reactor Co. v. Electricians*, 367 U.S. 396, 408 (1961).

For over 50 years—until it issued the rule involved in this case—the Board carried out its statutory mandate and determined bargaining unit questions on an individual, case-by-case basis. The courts therefore had no occasion to remind the Board of its obligation to do so. Nevertheless, in a few cases beginning shortly after the Act was

passed, this Court noted that the statute required case-by-case determination of bargaining-unit appropriateness and precluded reliance on the kind of inflexible rules the Board has now issued. For example, in *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944), the Court stated:

Wide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit. Congress was informed of the need for flexibility in shaping the unit to the particular case and accordingly gave the Board wide discretion in the matter. * * * The flexibility which Congress thus permitted has characterized the Board's administration of the section and has led it to resort to a wide variety of factors in case-to-case determination of the appropriate unit.

See also *NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985) (noting "Congress' recognition 'of the need for flexibility in shaping the [bargaining] unit to the particular case'"); *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947) ("[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision").⁶

⁶ The courts of appeals have rarely had occasion to address the meaning of the "in each case" requirement. But in those few cases where the language has been relevant, the courts of appeals have given effect to its plain meaning. For example, in holding that the Board could not accept a state agency's determination that a bargaining unit was appropriate, the Third Circuit emphasized that Section 9(b) required case-by-case determination by the Board:

Congress has thus mandated Board determination "in each case" of "the unit appropriate" for collective bargaining. Thus the statute requires the Board to exercise its discretion as to an appropriate unit in each and every case.

Memorial Hospital of Roxborough v. NLRB, 545 F.2d 351, 360 (3d Cir. 1976). See also *NLRB v. Cardox Div. of Chemetron Corp.*, 699 F.2d 148, 155-156 (3d Cir. 1983); *Big Y Foods, Inc. v. NLRB*,

(Footnote continued on following page)

The Board deviated from its consistent observance of the "in each case" mandate briefly in the 1970s in cases involving the health care industry, but quickly reversed course and concluded that its deviation had violated Section 9(b). In a short-lived series of cases, the Board established and applied an irrebuttable presumption that in every hospital a separate unit of registered nurses was to be considered appropriate *per se* and that evidence to the contrary would not be admitted. *St. Francis Hospital of Lynwood*, 232 NLRB 32 (1977), enforcement denied, 601 F.2d 404 (9th Cir. 1979); *Methodist Hospital of Sacramento, Inc.*, 223 NLRB 1509 (1976); *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975). After the courts of appeals rejected that approach, the Board admitted that it was contrary to the "in each case" requirement of Section 9(b):

We have concluded that so much of the Board's [decisions] as may be read to establish an irrebuttable presumption of the appropriateness of registered nurse units in all cases, without regard to particular circumstances, should be disavowed. Such a *per se* approach to unit determination is inconsistent with the Board's Section 9(b) responsibility to decide "in each case" whether the requested unit is appropriate.

Newton-Wellesley Hospital, 250 NLRB 409, 411 (1980). See also *St. Francis Hospital*, 271 NLRB at 951 n.17 (acknowledging "Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis"). Thus the Board, just a few years before it started down the rulemaking path, admitted that such an approach would violate Section 9(b).

⁶ continued

651 F.2d 40, 45-46 (1st Cir. 1981); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979); *Long Island College Hospital v. NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), cert. denied, 435 U.S. 996 (1978).

B. The Board's Rule Violates The Requirement Of Individual, Case-By-Case Bargaining Unit Determination

The Board's rulemaking disregarded the language and history of the statute and reversed 50 years of precedent by maintaining that Section 9(b) does not require that bargaining units be determined on an individual, case-by-case basis. NPR I, J.A. 15; NPR II, J.A. 46-47; Final Rule, J.A. 211-218. As we demonstrate above, the Board's revisionist view of the statute is plainly incorrect. But that was not the Board's only defense of its rule. The Board also made the incongruous assertion that its rule fulfilled the requirement of case-by-case determination:

There is nothing inconsistent between section 9(b) and the Board's use of its APA rulemaking power. Section 9(b) requires the Board to decide the appropriate unit in each case, and the Board will continue to do so under this rule. Should the parties not agree on the appropriate unit, a hearing in each case will still be directed, with the Board ultimately rendering a decision on the appropriate unit applicable to that particular petition and that particular employer's operation.

Final Rule, J.A. 214. The Board characterized its rule as establishing principles "of general applicability" that would be applied on a case-by-case basis. *Ibid.*

We agree that the Board could adopt rules establishing general principles to guide the required case-by-case bargaining unit determinations. For example, the Board could issue regulations stating the factors regional directors should weigh in determining bargaining unit appropriateness. But the rule at issue in this case does not merely establish general principles to guide case-by-case determinations. By its express terms, the rule is intended to preclude any individual case-by-case evaluation by ordering that the eight designated bargaining units "shall be appropriate units, and the *only* appropriate units" for acute-

care hospitals "[e]xcept in extraordinary circumstances." Final Rule, J.A. 259 (emphasis added).

The Board has made it quite clear that it views the "extraordinary circumstances" exception as so narrow as to be illusory. The Board warned that "[t]o satisfy the requirement of 'extraordinary circumstances,' " a party would have to bear the 'heavy burden' to demonstrate * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field * * *." NPR II, J.A. 189-190. The Board expressly rejected the notion that it was simply establishing presumptions that those eight units were appropriate. Final Rule, J.A. 217; NPR I, J.A. 21. Moreover, the Board issued a long list of factors that it would not even consider as potential extraordinary circumstances. See note 5, *supra*. By refusing to even consider such things as the organizational structure of the hospital and the duties and working conditions of the employees involved, the Board completely disregards the very factors it considers most relevant to bargaining unit determinations in all other industries.⁷

In these circumstances, there can be no question that the Board's rule violates Section 9(b)'s requirement of meaningful, case-by-case bargaining unit determination. The Board's promise that each case would receive an individual hearing is an empty one. In the hearings it would hold under the rule, the Board would not even allow the introduction of evidence relating to the factors that the Board itself regards as crucial to bargaining-unit determi-

⁷ In every other industry, the "similarity of duties, skills, interests, and working conditions of the employees" and the "organizational structure of the company" are among the most important factors to be considered in determining bargaining unit appropriateness. C. Morris, *The Developing Labor Law* 414 (2d ed. 1983). See also *Birdsall, Inc.*, 268 NLRB 186, 190-192 (1983); R. Gorman, *Basic Text On Labor Law* 69 (1976).

nations in *all* other industries. Instead, the Board simply would verify whether the bargaining unit in question is one of the eight listed in the rule, and on that basis alone automatically declare the unit appropriate. The Board has established not merely a principle of general applicability, or even a rebuttable presumption of fact; instead, it has established a presumption of law that applies even when the facts are to the contrary. Thus the rule defies the Act's requirement of meaningful, case-by-case consideration.

C. The Reasons Given By The Court of Appeals For Disregarding The "In Each Case" Requirement Cannot Withstand Analysis

Even though the language of the statute and its legislative history, as well as the manner in which the statute has been interpreted and applied over the years by the courts and the Board, demonstrate that Section 9(b) requires individual, case-by-case determinations of bargaining unit issues, the court of appeals held to the contrary. The court gave three reasons for its conclusion, but none of them can withstand analysis.

1. First, the court of appeals held that "such interpretations are regularly rejected in decisions involving challenges to agency rules, such as the Social Security Administration's 'grid' method of deciding entitlement to disability benefits. *Heckler v. Campbell*, 461 U.S. 458, 467-68 (1983)." Pet. App. 6a. But the statute involved in *Campbell* did not include any language analogous to the "in each case" requirement of Section 9(b). Moreover, this Court upheld the rule involved in *Campbell* because it involved "an issue that is not unique to each claimant." 461 U.S. at 468. The Court merely held that an "agency may rely on its rulemaking authority to determine issues that *do not require case-by-case consideration*." *Id.* at 467 (emphasis added). By contrast, bargaining unit determinations *do* involve issues that are unique to each employer.

By their nature—and by the language of the statute—they *do* require case-by-case consideration.⁸

A closer look at the *Campbell* decision and the rules at issue in that case actually supports AHA's position that the Board's bargaining-unit rule is invalid. The Social Security Act requires the Secretary of Health and Human Services to make a two-part determination. As the Court explained (461 U.S. at 467-468):

[The Secretary] must assess each claimant's individual abilities and then determine whether jobs exist that a person having the claimant's qualifications could perform. The first inquiry involves a determination of historic facts, and the regulations properly require the Secretary to make these findings on the basis of evidence adduced at a hearing. We note that the regulations afford claimants ample opportunity both to present evidence relating to their own abilities and to offer evidence that the guidelines do not apply to them. The second inquiry requires the Secretary to determine an issue that is not unique to each claimant—the types and numbers of jobs that exist in the national economy.

The issues that the Board's rule conclusively determines are like the issues involved in the *first* part of the disability determination: they are matters of historic fact, unique to each hospital. The question of whether a particular bargaining unit is appropriate to a particular hospital (and the question of whether the unit would cause prolifera-

⁸ In upholding the regulations in *Campbell*, the Court relied on its previous decisions in *Federal Power Comm'n v. Texaco, Inc.*, 377 U.S. 33, 40 (1964), and *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). The Court was careful to emphasize that in those cases—as in *Campbell*—"an individual applicant [was allowed] to show that the rule promulgated should not be applied to him." 461 U.S. at 467 n.11. In this case, however, the Board has foreclosed that possibility by making it clear that the rule applies in *all* cases, except in the rare instance where there are "extraordinary circumstances" warranting a different result.

tion) involves such issues as the size, location, staffing patterns and operation of the hospital, the degree of functional integration of the workforce, and so on—all unique factual matters that the Board will no longer consider even as possible extraordinary circumstances. NPR II, J.A. 188. It is simply nonsense to regard these issues as analogous to the national availability of jobs issue that the Court held could be determined by rule-making.

2. The court of appeals also reasoned that the "in each case" language was intended to prevent the Board from siding with either "of the two major labor federations, the AFL and the CIO—the former a federation of craft unions, the latter of plant unions." Pet. App. 7a. The court stated that "[i]f the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically. The 'in each case' proviso forbids the Board to do this." *Ibid.*

But the "in each case" language and the entire Act predates the dispute between the AFL and the CIO. The language was added to the Wagner bill in May 1935, and the NLRA was passed the next month. The CIO was formed initially as a committee within the AFL after the AFL convention in October 1935, and did not break away as a separate federation until 1938. As a leading historian of the Act has commented, "[n]one of the draftsmen [of the Wagner Act] foresaw the cleavage in the union movement that appeared later in 1935." I. Bernstein, *The New Deal Collective Bargaining Policy* 96 (1950).⁹

⁹ See also I. Bernstein, *The Turbulent Years* 400-402, 697-698 (1970); W. Galenson, *The CIO Challenge To The AFL* 3 (1960) ("November 9, 1935 [is] the date usually given as the birthday of the CIO").

At the time the Act was passed there were unions within the AFL that supported industrial unionism rather than the traditional craft approach. Section 9(b) recognizes the difference in view between craft and industrial unions (and declines to decide which view is correct) by providing that the appropriate unit "shall be the employer unit, craft unit, plant unit or subdivision thereof." If the requirement that "[t]he Board shall decide [the appropriate unit] in each case" is at all related to the disagreement between craft and industrial unionists, it is to the extent that Congress did not want the Board to issue any blanket declarations that either craft or industrial units would always be deemed appropriate. Instead, Congress wanted the Board to decide the appropriate unit "in each case."

In any event, whatever purpose Congress had in mind when it added the "in each case" requirement, the fact remains that Congress added those words to Section 9(b) and that the Board has improperly disregarded them. Moreover, it is hard to see how a rule that designates certain craft units (e.g., registered nurses, physicians, business office clerical employees) as appropriate in every case and that absolutely precludes organization on an across-the-board, industrial basis can be regarded as consistent with the supposed intent of Congress to prevent the Board from siding with either the craft or the industrial unionists.

3. The court of appeals' third reason for holding that the "in each case" language did not preclude establishing bargaining units by rule was that it construed the legislative history (including the statement in several of the House Reports that the appropriateness of a bargaining unit "is obviously [a matter] for determination in each individual case") to mean only "that unit determination is a task meet for the Board rather than for either the Congress or the employees themselves." Pet. App. 7a-8a. In addition, the court concluded that if Congress had meant the "in each case" language to preclude the kind of rule-

making the Board has undertaken, "it is probable (no stronger statement is possible) that Congress would have made an explicit exception for unit determination" in Section 6 of the Act, which gives the Board rulemaking authority. *Id.* at 8a. Both assertions are incorrect.

To begin with, although other passages in the House Reports' discussion of Section 9(b) indicate that unit determination is a matter for the Board to decide, the statement that the question of whether a bargaining unit is appropriate "is obviously one for determination in each individual case" clearly relates to how bargaining units should be determined, and not to who should make that determination. That statement explains the "in each case" language, not the allocation of responsibility for the determination to the Board.

Nor is it even "probable" that Congress would have amended Section 6 to make it clear that bargaining unit determinations could not be performed by rulemaking. Congress *did* include an "explicit exception for unit determination"; that exception is the "in each case" language of the subsequent Section 9(b). It simply would have been redundant to repeat the specific exception of Section 9(b) within the more general rule of Section 6. Moreover, it requires a perversion of the normal tenets of statutory construction to argue that the general language of Section 6 overrides the specific language of Section 9(b).¹⁰

¹⁰ In *Heckler v. Campbell* this Court noted that the determination of a disability claimant's abilities required an individual, case-by-case determination. 461 U.S. at 467-468. Yet the Social Security Act gives the Secretary broad rulemaking powers and does not specifically state that those powers do not apply to the Secretary's determination of an individual claimant's abilities. See 42 U.S.C. § 405(a).

II. The Board's Rule Is Contrary To The Congressional Admonition Requiring The Board To Take Special Care To Avoid Proliferation Of Bargaining Units In The Health Care Industry -

The Board's rule not only is contrary to the express language of Section 9(b), but it also is plainly inconsistent with the Health Care Amendments Act of 1974 and with the admonition contained in both the House and Senate Reports requiring the Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." Pet. App. 8a. The congressional admonition is relevant in two respects. First, it stands as a reaffirmation of the requirement of case-by-case bargaining unit determination. Second, as an expression of the intent of Congress when it extended the National Labor Relations Act to cover nonproprietary hospitals, the admonition is an authoritative statement of the meaning of the Act as applied to that industry. And, as numerous courts of appeals have held, the admonition requires that the Board consider *in each case* whether the requested bargaining unit will result in or lead to an undue proliferation of units at the particular hospital. The Board's rule would dispense with that requirement.

A. The Congressional Admonition And The Legislative History Of The 1974 Amendments Confirm That Section 9(b) Requires Individual, Case-By-Case Determinations Of Bargaining Units

As we pointed out earlier (3-5, *supra*), the Health Care Amendments Act of 1974 was the product of a two-year legislative process. In 1972, the House of Representatives passed a bill that simply would have repealed the exemption of hospitals from the coverage of the National Labor Relations Act. 1974 *Leg. Hist.* at 10. That bill was opposed in the Senate by Senator Robert Taft, Jr., among others, and never was voted out of committee.

The following year, Senator Taft sponsored a new bill (S. 2292) that would also have extended the Act's coverage to include hospitals. 1974 *Leg. Hist.* at 106. But in addition it would have designated four units as the only appropriate bargaining units in all hospitals: professionals, technicians, office clericals, and other nonprofessionals. *Id.* at 457-458. That bill was opposed as overly rigid and unduly restrictive of the Board's flexibility to determine bargaining units on a case-by-case basis taking into account the particular situation at each hospital. *Id.* at 113-114. During the hearings on Senator Taft's bill, the Department of Labor took the position that "with regard to unit determinations * * * the existing procedures, particularly as they have worked in the for-profit hospitals, and the other health care fields, are sufficient to meet the need." 1973 *Hearings* at 434. Those existing procedures, of course, included case-by-case bargaining unit determinations.¹¹

In light of those objections, Senator Taft withdrew his bill before it ever came to a vote in committee.¹² Senator

¹¹ The Labor Department spokesman gave as an example of the success of the existing procedures the Board's ruling in the *Ea-tendicare* case, where, in light of the particular facts involved, the Board *rejected* separate units of technical employees and service and maintenance employees on the ground that separate units "would create unwarranted unit fragmentation." 1973 *Hearings* at 427. The Board's rule would allow those separate units.

¹² In these circumstances, it would be inappropriate to construe the fact that S. 2292 was never enacted—and never even voted upon—as demonstrating that Congress believed four units were too few. As the Board concluded before it decided to engage in rulemaking, "[t]he mere fact that the Taft proposal was not included in the enacted legislation may not properly be attributed to its being perceived as numerically too restrictive." *St. Francis Hospital*, 271 NLRB 948, 951 n.17 (1984). As a general matter, congressional inaction "affords the most dubious foundation for drawing positive inferences." *United States v. Price*, 361 U.S. 304, 310-311 (1960). See also *Pension Benefit Guaranty Corp. v. LTV Corp.*, 110 S. Ct. 2668, 2678 (1990); *United States v. W.M. Webb*,

(Footnote continued on following page)

Taft—through his staff—then entered into “protracted discussions” with all of the parties concerned, obtained agreement in principle, and introduced a compromise bill that became the Health Care Amendments Act of 1974. *1974 Leg. Hist.* at 111. Because of the objections to S. 2292, the Act did not limit the Board’s flexibility to determine the appropriate unit on a case-by-case basis. Instead, it was accompanied by agreed-upon language in both the Senate and House Reports requiring that the Board, in carrying out its required case-by-case determinations, give “[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry.” S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6 (1974).

Senator Taft explained the legislative process and the meaning of the admonition as follows:

The issue of proliferation of bargaining units in health care institutions has also greatly concerned me during consideration of legislation in this area. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. The provisions of S. 2292 placed a statutory limit of four bargaining units in a health care institution. While this precise approach was not adopted by the committee, report language was agreed upon to stress the necessity to the Board to reduce

¹² *continued*

Inc., 397 U.S. 179, 194 n.21 (1970). It is entirely possible that some in Congress may have opposed S. 2292 because they opposed any repeal of the hospital exemption, others because they believed that all nonprofessionals should be in a single unit, and yet others because it did not contain some of the other protections eventually incorporated into the 1974 Act.

and limit the number of bargaining units in a health care institution.

* * *

I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented.

1974 Leg. Hist. 113-114.¹³

The congressional admonition was thus part of a compromise under which the Board retained its authority to determine the appropriate unit in each case rather than have that discretion limited by the designation in the statute of particular units as appropriate. Although the

¹³ Senator Harrison A. Williams, Chairman of the Senate Labor Committee and a co-sponsor of the bill, argued that the Board should give due consideration to avoiding proliferation, and emphasized that such consideration should occur within the framework the Board had always used to determine appropriate bargaining units (i.e., individual, case-by-case determinations):

[T]he National Labor Relations Board has shown good judgment in establishing appropriate units for the purposes of collective bargaining, particularly in wrestling with units in newly covered industries. While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications.

While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargain[ing] units. (*NLRB v. Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3d Cir. 1942)).

1974 Leg. Hist. 362-363.

Board's flexibility was retained, it was made subject to the requirement that in addition to considering all of the other case-specific factors involved in bargaining-unit determinations, the Board take special care to consider whether approval of the unit in question would result in or lead to proliferation of bargaining units at that hospital. The congressional admonition in this manner reaffirmed the need for case-by-case unit determinations and underscored Section 9(b)'s requirement that the Board determine the appropriate unit "in each case." By designating certain specific units as the only appropriate units in the industry—and by thus doing exactly what Congress decided *not* to do—the Board has clearly violated the statute.

B. The Board's Rule Is Contrary To The Intent Of Congress As Expressed In The Congressional Admonition

In addition to confirming Congress's understanding that Section 9(b) requires case-by-case determinations of appropriate bargaining units, the congressional admonition is an authoritative statement of what Congress intended when it extended the Act's coverage to include nonproprietary hospitals. As numerous courts of appeals have held, the admonition requires the Board to determine—in each case—whether approval of the bargaining unit at issue will result in or lead to proliferation. It is ironic indeed that under the Board's rule, the *only* industry as to which the Board does not provide meaningful, case-by-case determination of bargaining unit appropriateness is the one industry as to which Congress specifically admonished the Board to take special care. Instead of giving due consideration to preventing bargaining-unit proliferation in the health care industry, the Board's rule discards its traditional, case-by-case approach and takes no particularized care at all.

1. In its rulemaking, the Board offered three responses to the claim that it had ignored the congressional admoni-

tion. First, the Board argued that the eight bargaining units required by the rule do not present the kind of proliferation problem that concerned Congress. "Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately." NPR II, J.A. 191. See also Final Rule, J.A. 246-254.

There are two flaws in the Board's reasoning. To begin with, it trivializes the proliferation problem that concerned Congress by characterizing it simply as a matter of numbers. The legislative history—including the rejection of the 1972 bill that merely would have repealed the exemption of nonproprietary hospitals without further comment, the opposition to Senator Taft's bill that would have designated four appropriate units, and the passage of the final bill with the admonition against proliferation in both the Senate and the House reports—demonstrates that Congress was acutely concerned with proliferation, but rejected any approach that would have specified any particular type or number of units as appropriate. Instead, it directed the Board to continue to exercise flexibility in determining hospital bargaining units on a case-by-case basis, and in doing so to give "due consideration" to avoiding any proliferation of bargaining units.

Congress's approach acknowledges the fact that hospitals vary greatly one from another, and as a result have different bargaining histories, different numbers of existing bargaining units, and different sizes and organizational structures. At some hospitals, approval of a new unit of skilled maintenance employees may not result in proliferation,¹⁴

¹⁴ For example, that unit might be the first in the hospital to organize and other units might be unlikely. Of course, the Board also should consider whether approval of that unit is likely to lead to proliferation of units in the future.

but in other hospitals it might.¹⁵ Only by heeding the congressional admonition and considering the proliferation issue in each case (as it is required to do by Section 9(b)) can the Board determine the impact of an additional bargaining unit on a particular hospital. No magic number of units is automatically excessive or always appropriate. And no particular unit or number of units is certain in every case not to cause the problems that concerned Congress.

Accordingly, nearly all of the courts of appeals have held *not* that a particular unit or number of units is excessive *per se*, but instead that the Board must consider the proliferation issue in each case. As the Ninth Circuit put it:

“[D]ue consideration” demands individual examination by the Board, or its delegate, of the circumstances of each particular case in order to determine the propriety of the proposed unit in light of the congressional directive and the public interest.

NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 416 (9th Cir. 1979). See also *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 812 (9th Cir. 1982) (Kennedy, J.) (“Our holding should not be taken to imply that a separate unit for RNs is necessarily suspect; we simply are in no position to review compliance with the statute absent a legal and factual analysis by the NLRB of the nonproliferation issue”). Most of the other circuits have reached the same conclusion. See, e.g., *NLRB v. Mercy Hospital Ass’n*, 606 F.2d 22, 27 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 970-

¹⁵ For example, the bargaining history of the hospital might already show a tendency toward frequent work stoppages and the new unit may create the likelihood of jurisdictional disputes with existing units. Consideration of the size of the particular hospital, its organizational structure, and the interaction among employees also may show that the proposed unit would create or lead to undue proliferation or would otherwise be inappropriate.

971 (3d Cir. 1979); *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191, 194 (4th Cir. 1982); *Bay Medical Center v. NLRB*, 588 F.2d 1174, 1176-1177 (6th Cir. 1978), cert. denied, 444 U.S. 827 (1979); *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858, 863 (7th Cir. 1980); *Watsonwan Memorial Hospital, Inc. v. NLRB*, 711 F.2d 848, 850 (8th Cir. 1983); *Beth Israel Hospital & Geriatric Center v. NLRB*, 688 F.2d 697, 700 (10th Cir.), cert. dismissed, 459 U.S. 1025 (1982); *NLRB v. Walker County Medical Center, Inc.*, 722 F.2d 1535, 1539 (11th Cir. 1984).¹⁶

By designating the eight bargaining units as appropriate in every case, the Board has completely eliminated any opportunity for consideration of whether approval of one of those units in a particular instance would lead to the problems that concerned Congress. The Board supported its rule by observing that all eight units will not be present in every case. Final Rule, J.A. 250-251; NPR II, J.A. 193. That might be true, but even in those hospitals where all eight units *are* present, the Board’s rule would preclude individual consideration of the effect of those units on the hospitals.¹⁷ The rule thus is contrary to the intent of Congress—and to the meaning of Section 9 as applied to this industry—that the Board give due consideration to avoiding proliferation of bargaining units in each case.¹⁸

¹⁶ The First and Fifth Circuits have not considered the issue. The sole exception is the District of Columbia Circuit, which reached the contrary conclusion in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697, 704-705 (D.C. Cir. 1987).

¹⁷ It even appears that the Board will not even consider the proliferation issue in cases where its rule would lead to *more than eight units*. In situations where there are already units in existence that do not conform to the Board’s rule (and which may number more than eight), the Board will nevertheless approve *additional* units without considering the proliferation issue if they “comport, insofar as practicable, with the appropriate unit set forth in [the rule].” Final Rule, § 103.30(c), J.A. 260.

¹⁸ In arguing that Congress was concerned only with the possibility of “scores of units,” the Board has attempted to characterize

(Footnote continued on following page)

The Board's argument that Congress was concerned only about "the possibility of scores of units" is flawed in yet another respect. It certainly is true that in opposing the bill, hospital industry representatives cited some extreme examples of proliferation, both in their industry and in others (i.e., the construction and newspaper industries). But that hardly means that their concerns were limited to avoiding those extremes. As the Second Circuit put it, "Congress was expressing concern not only that health care institutions be spared the egregious unit proliferation of the construction trades but that less extreme unit fragmentation arising from application of usual industrial unit criteria could also impede effective delivery of health care services." *NLRB v. Mercy Hospital Ass'n*, 606 F.2d at 27. As one Board member noted, it would be a "remarkable construction of the legislative history" to take out of context the citation of one "particularly undesirable example of unit proliferation" and characterize it as defining the whole of congressional concerns. *Allegheny General Hospital*, 239 NLRB 872, 883 (1978) (Member Penello

¹⁸ continued

the 1974 Act and the congressional admonition as a compromise between those who wanted simply to repeal the exemption of the hospital industry from the coverage of the Act and those who supported Senator Taft's earlier bill (S. 2292) repealing the exemption but allowing only four bargaining units. See [Court of Appeals] Brief for the National Labor Relations Board at 34-39. That is misleading. Although some industry groups endorsed the earlier Taft bill as a necessary compromise, much of the industry opposed altogether any repeal of the exemption. See 1974 *Leg. Hist.* at 46: ("S. 3203 represents a compromise between those parties favoring a simple repeal of the existing exemptions from Taft-Hartley coverage for nonprofit hospitals and some of those resisting such a repeal") (statement of Sen. Dominick). The congressional admonition cannot be regarded as a compromise between those who favored four units and those who favored "scores of units." Instead, it was a compromise between those who favored repeal of the hospital exemption and those who opposed repeal. The nature of the compromise was to require the Board carefully to consider the proliferation issue as it considered other issues in the required case-by-case assessment of bargaining unit appropriateness.

dissenting), enforcement denied, 608 F.2d 965 (3d Cir. 1979).¹⁹

One can search in vain through the House and Senate Reports and the comments of members during the debates to find any statement that Congress's concern was limited to the possibility of "fifteen to twenty plus units" or "scores of units" and that Congress would be satisfied with any number less than 15. To the contrary, the congressional reports expressed approval of cases taking a far more restrictive approach. In the admonition, Congress "note[d] with approval" the Board's decision in *Four Seasons Nursing Center*, 208 NLRB 403 (1974), and *Woodland Park Hospital*, 205 NLRB 888 (1973).²⁰ In *Four Seasons*, the Board rejected a separate unit of skilled maintenance workers, one of the units the Board's rule would establish. The Board indicated that the maintenance workers should be included in the same unit with other nonprofessional employees.

¹⁹ In denying enforcement of the Board's order, the Third Circuit cited Member Penello's dissenting opinion with approval. 608 F.2d at 968-969.

²⁰ Congress also noted with approval "the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB 1232 (1973)," although it indicated in a footnote that "we do not necessarily approve all of the holdings" of *Extendicare*. 1974 *Leg. Hist.* at 12, 275. In that case, the Board rejected separate units of technical employees and service and maintenance employees, noting that "a finding that two separate units are appropriate would create unwarranted unit fragmentation." 203 NLRB at 1233. (Of course, those units would be approved under the Board's rule.) But the Board permitted a separate unit of licensed practical nurses, and doubts about the propriety of separating that unit led Congress to include the footnote indicating that it did not necessarily approve of the entire decision. See 1974 *Leg. Hist.* at 255; *St. Vincent's Hospital v. NLRB*, 567 F.2d 588, 591 n.5 (3d Cir. 1977); C. Morris, *The Developing Labor Law* 437-438. The admonition's reference to *Extendicare* thus clearly shows a preference for broader units than those now designated as appropriate by the Board.

In *Woodland Park Hospital*, the Board's Regional Director originally set a broad bargaining unit of nonprofessional employees, but then decided to allow x-ray technicians to form a separate unit. The Board *rejected* that separate unit and ordered that the x-ray technicians be included in a broad nonprofessional unit—a single unit that would encompass *four* of the eight units the Board's rule would regard as separately appropriate.²¹ Thus, in both of these cases the Board favored units far broader than the eight the Board now seeks to designate as appropriate in every case. And Congress expressly approved that approach.

2. In addition to claiming that Congress was concerned only with the possibility of 15 or 20 bargaining units, the Board asserted in its rulemaking that it could properly ignore the congressional admonition because it was of no binding effect. Final Rule, J.A. 247-248. The Board argued that because "section 9(a) was not changed in 1974," the congressional admonition is a nullity. *Ibid.*

That argument ignores the fact that insofar as the hospital industry is concerned, the *entire* statute was amended in 1974. As the court of appeals held:

The admonition * * * accompanied the enactment of substantial amendments. The particular statutory provision to which the admonition was addressed was not amended, but the effect of the amendments was to apply that provision for the first time to the nonproprietary hospital industry. Section 9(b) directs the Board to determine the "appropriate" unit, and what is appropriate may differ from one industry to another—may therefore "mean" something different in one industry from what it means in another. So in

²¹ The broad unit designated by the Board in *Woodland Park Hospital* included the technical employees, skilled maintenance employees, business office clerical employees, and other nonprofessional employees units designated as appropriate by the Board's rule.

changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words. The admonition can therefore be regarded as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action—the case in *Pierce v. Underwood*, 108 S. Ct. 2541, 2551 (1988), and *Center for Auto Safety v. Peck*, 751 F.2d 1336, 1351 (D.C. Cir. 1985).

Pet. App. 11a-12a.

We certainly agree that "legislative history" unrelated to the enactment of legislation is of no impact. But that is not the case with the congressional admonition. Because the entire statute was amended in 1974 insofar as the health-care industry is concerned, the legislative history of the 1974 amendments is an authoritative indication of what Congress intended when it expanded the Act's coverage. That particularly is true where, as here, the legislative history is entirely consistent with the original act and requires the Board to continue to do what the original act required: consider bargaining unit issues on an individual, case-by-case basis taking into account the circumstances of the particular industry and employer (including whether the requested unit would result in or lead to a proliferation of bargaining units).

3. The Board offered yet a third reason why the congressional admonition against proliferation of bargaining units should not be permitted to stand in the way of its rulemaking. The Board argued that the admonition should be ignored because Congress based it on incorrect premises:

The legislative history showed "proliferation" was opposed by Congress because it was feared that [it] would lead to numerous work stoppages, jurisdictional disputes, and wage whipsawing and leapfrogging. However, as was amply documented in NPR II, multiple units have not been shown to cause an unusual num-

ber of work stoppages, nor have they been shown to have caused jurisdictional disputes, wage whipsawing, or leapfrogging.

* * *

[T]he evidence presented to us is that there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.

Final Rule, J.A. 251-252.

There are two critical defects in the Board's argument. First, the Board's "finding" that multiple units have not caused the problems Congress anticipated ignores the fact that there has *not* been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach. Had there been a proliferation of units, the Board then might have been able to examine its impact. But since the courts have prevented any proliferation from occurring, the Board's "finding" that proliferation has not caused problems is sheer speculation based on little or no evidence.

Moreover, and more important, it is not for the Board to redetermine legislative facts already determined by Congress. As the Board acknowledges, Congress reviewed the evidence (including extensive testimony from both union and industry representatives) and found that proliferation of bargaining units *would* cause work stoppages, jurisdictional disputes, whipsawing and leapfrogging. J.A. 251. If the Board believes that Congress's findings have been proven wrong, the appropriate course is to ask Congress to reconsider the issue, not to violate the agency's statutory mandate.

III. The Board's Rule Is Arbitrary And Capricious And Not Supported By Substantial Evidence Insofar As It Ignores Critical Differences Among Hospitals

As we demonstrate above, the language and legislative history of Section 9(b) and of the 1974 amendments do

not permit the Board to establish by rule that certain bargaining units—and only those units—are appropriate for all acute-care hospitals. But even if the statute authorized the Board to adopt such a rule as a general matter, the rule at issue in this case would still be invalid. The rule is arbitrary, capricious, and not supported by substantial evidence insofar as it ignores critical differences among the more than 4,000 acute-care hospitals in the United States, including differences in size, location, operations, and workforce organization. Although the district court found it unnecessary to reach this issue (Pet. App. 41a n.17), the court of appeals—without any detailed examination of the evidence in the record—held that the rule was not arbitrary. Pet. App. 14a-16a.

The court of appeals characterized AHA's argument that the rule improperly lumped together hospitals of greatly differing size, missions, and locations as "an important criticism" (Pet. App. 14a) and agreed that the Board's rigid rule "overlook[s] a great deal of relevant diversity." *Id.* at 15a. Indeed, until this rulemaking procedure, the Board itself had concluded that a case-by-case approach to bargaining units was necessary in light of the diversity of the industry. *St. Francis Hospital*, 271 NLRB at 953 n.39.

Nevertheless, the court of appeals upheld the Board's rule treating all acute-care hospitals alike without conducting any real examination of the record evidence. The court based its result in large part on its view that the hospital industry had failed to propose adequate alternatives or to seek modification of the Board's rule (Pet. App. 14a):

[The industry's] important criticism * * * would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of a rule. * * * Another way in which the industry failed to respond construc-

tively to the Board's desire to bring unit determination in the acute-care hospital industry under a rule was by failing to press for an increase in the six-employee minimum [for employees in a unit].²²

The relevant issue, however, is not whether the hospitals offered and supported a reasonable alternative, but whether the Board's rule was "arbitrary," "capricious," or "unsupported by substantial evidence." 5 U.S.C. § 706(2)(A), (E). The court of appeals failed seriously to examine that issue. Instead, the court simply asserted that in view of the Board's "dismal" record in justifying its hospital-unit determinations to the courts of appeals, "it was not unreasonable for the Board to experiment with substituting a tight rule for a loose standard." Pet. App. 15a.

The hospital industry's position all along has been that it was folly for the Board even to try to develop a rule that would designate specific bargaining units as the only appropriate units in the industry because the great diversity in the industry makes such an approach inherently arbitrary and capricious. The Board acknowledged in *St. Francis Hospital* that the "diverse nature of the industry"—including both "small hospitals" and "large medical centers"—"precludes any generalization as to the appropriateness of any particular bargaining unit." 271 NLRB at 953 n.39. In the rulemaking, however, the Board completely reversed its position and claimed—supposedly based

²² The court of appeals also implied that the hospital industry was partially responsible for the Board's decision to treat all hospitals as if they were alike because it "joined the unions in opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." Pet. App. 14a. In actuality, the industry—while arguing that the number of beds did not adequately capture the differences between hospitals and that establishing bargaining units by rule was inherently arbitrary—agreed with the Board that a distinction should be made between large and small hospitals but proposed that the cutoff be set at a higher number than 100 beds. NPR II, J.A. 164.

on its experience in handling hundreds of hospital bargaining unit cases over the previous 13 years—that all such facilities were "remarkably uniform" and "virtually identical." NPR I, J.A. 12-14; NPR II, J.A. 188-189. The Board did not find that this supposed uniformity had suddenly developed in the last five years; and indeed, there was no evidence of any such radical change in the health care industry during that time. The Board simply jettisoned its previous findings concerning diversity in the industry.

The Board's new and drastically altered "findings" warranted more thorough analysis than that provided by either the Board or the court of appeals. The presumption in judicial review is "against changes in current policy that are not justified by the rulemaking record." *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 42 (1983) (emphasis in original). Because the Board's analysis directly conflicts with its longstanding assertion of the need for individualized unit determinations, the rulemaking analysis "is 'entitled to considerably less deference' than a consistently held agency view." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (citation omitted); see also *NLRB v. United Food & Commercial Workers Union*, 484 U.S. 112, 124 n.20 (1987).²³

²³ The Board's decision to adopt *per se* rules must also be scrutinized especially carefully because there are indications in the record that the Board had already reached its conclusion that a blanket rule was appropriate before ever holding any hearings. This conclusion is strongly suggested by the following interchange between Board members and Bert Subrin, the Board's counsel:

MR. SUBRIN:

By announcing the rules first and then ending up with the same rule it sort of sounds as if you did it by fiat and used the hearing to justify what you already decided; whereas, if you used the evidence that you've taken at the hearing to justify the rules, it sounds as if you were a little more open minded.

* * *

(Footnote continued on following page)

In fact, a close examination of "the whole record"—including "the body of evidence opposed to the Board's view" (*Universal Camera Corp. v. NLRB*, 340 U.S. 474, 487-488 (1951))—shows that the Board's current claim is unfounded, and that its earlier assessment was the correct one. In health care, as in other industries, "[w]ide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit." *NLRB v. Hearst Publications, Inc.*, 322 U.S. at 134.

The Board offered no reason why evidence of differences among hospitals did not undercut its finding that "there are such similarities that certain institutions may properly be grouped as a class." NPR II, J.A. 53. It blithely disregarded hundreds of letters submitted by hospitals detailing their size and workforce structure and the effect that the rule would have on their institutions. See Final Rule, J.A. 205-207. The Board dismissed these submissions as "form letters" (*ibid.*), but in fact a great many of the hospitals provided specific examples, with quantified costs, of the impact of the rule.²⁴ By ignoring the extensive

²³ continued

MR. SUBRIN:

Do you want discussion on whether there should be rulemaking? I would suggest that you just announce that the Board has decided to utilize [rulemaking] and instruct the law judges not to take evidence on that.

MEMBER BABSON: Absolutely. That bridge has been crossed. Transcript of the NLRB Meeting of May 15, 1987, RM-2-A-1 at 18, 29, reproduced in AHA's Court of Appeals Supplemental Appendix at 348-349.

²⁴ A review of a representative sample of the letters submitted shows that hospitals provided specific details on the impact of the rule. These letters are included in the record below and were reproduced in AHA's Court of Appeals Supplemental Appendix ("S.A.") at 369-378 and 412-417. Hospitals presented evidence that, to cut costs while maintaining adequate staffing under increasing

(Footnote continued on following page)

testimony concerning the differences in hospital size, location, and operations, the Board impermissibly "failed to consider an important aspect of the problem" and reached a conclusion "that runs counter to the evidence" before it (*State Farm*, 463 U.S. at 43).²⁵

In previous adjudications as well, the Board and its regional directors have made case-by-case findings that undercut the generalized conclusions adopted by the Board in the rulemaking proceedings.²⁶ Applying the very same factors allegedly taken into account in the rulemaking, the Board and its regional directors have often reached the

²⁴ continued

financial pressures, they have assigned employees to perform duties cutting across the traditional employment categories on which the Board's rules are based. See, e.g., S.A. 370 (comment of Marshalltown Medical & Surgical Center). Contrary to the Board's unsupported conclusions, the letters showed that artificial divisions between bargaining units have already caused operating inefficiencies, including hampering transfers of employees to other jobs and prompting jurisdictional disputes. See, e.g., S.A. 375-377 (comments of Michael Reese Hospital and Medical Center). The testimony detailed and quantified the costs that negotiations and strikes impose on a hospital—costs that are multiplied with each new separate unit. See, e.g., S.A. 381-382 (comments of St. Luke's Memorial Hospital Center); S.A. 379-380 (comments of Gerald Champion Memorial Hospital); S.A. 415 (comments of Burlington Medical Center); S.A. 388-393 (testimony of Susan S. Robfogel).

²⁵ The arbitrariness of the Board's reasoning is shown by the fact that it concluded, on evidence quite similar to that presented by the hospital industry, that nursing homes should not be covered by the Rules because there are "significant differences between the various types of nursing homes which affect staffing patterns and duties." NPR II, J.A. 170. For example, the Board found it significant that nursing homes range in size from 10 to 500 patients and provide varying levels of care (NPR II, J.A. 166), but discounted the evidence that acute-care hospitals range in size from less than 25 beds to more than 1,000 and provide even more varying levels of care (compare the size and circumstances of Sitka Community Hospital with those of Michael Reese Hospital and Medical Center, S.A. 372-378).

²⁶ AHA has lodged copies of these decisions with the Clerk of the Court.

exact opposite conclusions in the light of particular factual circumstances. For example, while the Board assumed throughout the rulemaking that employees within a given classification at different hospitals perform essentially similar tasks, the Board had previously found that small or rural hospitals, given their limited resources, often required that employees perform atypical functions.²⁷ Likewise, the Board's assumption that so-called "skilled" maintenance employees invariably differ sharply in tasks and skills from other service and maintenance employees (NPR II, J.A. 132-149) is untrue at many hospitals where all maintenance workers assist in tasks throughout the hospital, coming in contact with service workers, and particularly where complex maintenance work is farmed out to independent contractors.²⁸ To give yet another example, the assumption that business clerical workers invariably differ from and have little contact with other non-profes-

²⁷ See, e.g., *Jay Hospital*, No. 15-RC-7171, at 4 (1985) (smallness of hospital leads to high degree of interdependence and contact between different employees and departments); *Jewish Hospital Rehabilitation Center of N.J.*, Nos. 22-RC-9442, 22-RC-9443 & 22-RC-9444 at 12 (1985) (at 50-bed hospital, RNs and LPNs (which rules divide into separate units) have virtually identical functions and employment conditions); *Titusville Hospital*, No. 6-RD-973, at 15 (1986) (small size requires that LPNs sometimes fill functions of RNs); *Twin City Hospital Corp. Cases*, Nos. 8-RC-13686, 8-RC-13687, at 6 (1987) (at small hospital, medical technologists (whom rules place in separate technical unit) have to assume responsibilities of professionals, "develop[ing] greater skills and us[ing] greater discretion and judgment than would be necessary in a large facility").

²⁸ See, e.g., *Wilmington Medical Center*, No. 4-RC-14780, at 2 (1985) (maintenance employees had frequent contact with other employees, and many had worked in service departments; while maintenance workers possessed some skills, complex work was performed by independent contractors); *St. Joseph Hospital*, No. 4-RC-14543, at 3 (1984) (while maintenance employees possessed a certain degree of skill, they had frequent contact with other employees and worked mostly outside their department, and complex maintenance work was performed by outside contractors).

sional employees is belied by the findings in numerous cases.²⁹

Perhaps the most telling example is the Board's conclusion that technical employees must be in a separate unit from skilled maintenance employees. NPR II, J.A. 122-123. In reaching that conclusion, the Board compared the skills and working conditions of technical employees with those of service and maintenance workers, and in most respects avoided any comparison with the skilled maintenance unit it was also creating. *Id.* at 123-132. In fact, many of the factors the Board used to distinguish technical employees from service and maintenance workers (skill level, wages, education, licensure, separate supervision, limited contact with other employees) were used just a few pages later to distinguish skilled maintenance employees from other service and maintenance workers. *Id.* at 133-149. But more important is the fact that the Board concluded that it was necessary to separate the very same units it said in the *Extendicare* decision had to be combined to prevent "unwarranted unit fragmentation." 203 NLRB at 1233. *Extendicare* was not only noted with approval in the congressional admonition, but the decision in that case to combine technical employees and service and maintenance workers in a single bargaining unit was also used by the Administration during the legislative hearings as a prime example of how existing Board procedures would work to avoid undue proliferation of bargaining units. 1973 *Hearings* at 427.

²⁹ In its rulemaking (J.A. 159-160), the Board admitted reaching the opposite conclusion in *Baker Hospital, Inc.*, 279 NLRB 308, 309 (1986) (clericals had same terms and conditions of employment as, and extensive contact with, service and maintenance workers). See also, *Santa Rosa Memorial Hospital*, No. 20-RC-15845, at 4 (1985) (geographic separation of certain finance employees insufficient to overcome other factors indicating community of interest with other non-professional workers).

Contrary to the court of appeals' assertion (Pet. App. 15a-16a), the arbitrariness of the Board's rule cannot be defended on the ground that numerous courts had rejected the Board's prior attempts to determine units on a case-by-case basis. The courts did not reject those efforts because the Board complied with the statutory requirement to determine the appropriate unit "in each case." Rather, the courts criticized the Board for failing fully to consider the effect of the proposed unit on the particular hospital involved. See, e.g., *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d at 194-195; *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, 678 F.2d at 812; *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 416.

The Board concedes that its rule designates as appropriate much the same eight bargaining units that it recognized between 1974 and 1984. Final Rule, J.A. 252. But designating the appropriate units by rule does not alleviate in any way the problem that led the courts of appeals to reject the Board's prior efforts. Instead, the Board's use of rulemaking merely compounds the problem by mandating that the differences between hospitals be ignored and by precluding any consideration of the appropriateness of the bargaining unit at the particular institution or of the possibility that approval of the unit would result in or lead to an undue proliferation of units.³⁰ By pretending against the weight of the evidence that all hos-

³⁰ As Member Johansen aptly put it in his dissent from the Board's rulemaking, "unit specifications derived from a predetermined set of rules are inherently less flexible than those arrived at by decision in individual cases" and are subject to intense criticism whenever they are applied "on the ground that the Board has not arrived at a result through the application of its institutional expertise to a particular fact pattern." NPR II, J.A. 201.

pitals are alike, the Board's rule is inherently arbitrary and capricious.

It is easy to understand the frustration that led the Board to engage in rulemaking. In 1987 the Board complained that after "[t]hirteen years and many hundreds of cases * * * it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974." NPR I, J.A. 9. But the answer to that complaint is neither to violate the statutory requirement of case-by-case unit determinations nor to ignore the differences among hospitals. Instead, it is to follow the procedure used with great success in every other industry over the past 55 years and to determine the appropriate unit in each case, taking into account the circumstances of the particular hospital and the possibility that approval of the requested unit would lead to proliferation. If the courts of appeals are in conflict over the proper standard the Board is to apply in determining unit appropriateness,³¹ it should ask this Court to resolve that conflict. As tempting as it must have seemed, it is no solution to try to avoid any possibility of case-by-case judicial review by ignoring the requirements of the statute and the diversity of the industry.

³¹ A conflict among the circuits was created by the decision of the District of Columbia Circuit in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d at 704-705. As that court acknowledged, the courts of appeals disagreed over whether the Board was permitted to apply its usual "community-of-interests" standard to the health care industry or was instead required to apply a "disparity-of-interests" standard. See NPR II, J.A. 199 (Member Johansen, dissenting).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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AMERICAN HOSPITAL ASSOCIATION, PETITIONER

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

**BRIEF FOR THE
NATIONAL LABOR RELATIONS BOARD**

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QUESTIONS PRESENTED

The National Labor Relations Board has promulgated a regulation specifying the eight types of units that—in the absence of extraordinary circumstances—will be recognized as appropriate for collective bargaining in acute-care hospitals. The questions presented are:

1. Whether the regulation violates the provision of Section 9(b) of the National Labor Relations Act, 29 U.S.C. 159(b), that the “Board shall decide [the appropriate bargaining unit] in each case.”

2. Whether the regulation is consistent with 1974 amendments to the National Labor Relations Act that extended the Act to nonprofit health care institutions, and with statements in the amendments’ legislative history admonishing the Board to give “[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry.”

3. Whether the regulation is arbitrary and capricious in prescribing the same bargaining units for all acute care hospitals absent a showing of extraordinary circumstances.

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In the Supreme Court of the United States

OCTOBER TERM, 1990

No. 90-97

AMERICAN HOSPITAL ASSOCIATION, PETITIONER

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF FOR THE
NATIONAL LABOR RELATIONS BOARD

STATEMENT

In 1974, Congress extended the National Labor Relations Act to nonprofit health care institutions. For the next 13 years, hospitals, labor organizations, and the National Labor Relations Board engaged in sharp disputes—aptly characterized by one commentator as a “conceptual World War I,” 4 T. Kheel, *Labor Law* § 14.03[7] (1989)—concerning the units appropriate for collective bargaining in those institutions. In 1987, to end unproductive controversy and to facilitate the exercise of rights protected by the Act, the Board initiated its first major substantive rulemaking proceeding.

Over the course of the next two years, the Board assembled information concerning conditions in the health care industry and refined its proposed rule. Relying on the rulemaking record and on experience derived from

numerous adjudications of hospital bargaining units, the Board determined that "acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units" and that "the policies of the Act would better be effectuated by the establishment of appropriate units in [certain] segments of this industry by exercise of the Board's * * * rulemaking authority." J.A. 189.

The regulation embodying this judgment applies to "acute care hospitals," a defined category of institutions engaged primarily in providing short-term patient care. J.A. 261. The regulation provides for eight bargaining units (which may or may not be organized in a given hospital and in which the placement of certain individual employees will be resolved through adjudication): two units of professionals (registered nurses and doctors), three units of nonprofessionals (technical employees, skilled maintenance employees, and business office clericals), two residual units (all other professionals and all other nonprofessionals), and, as required by the statute, a separate unit of guards. J.A. 259-260; see 29 U.S.C. 159(b)(1) and (3). There are several exceptions. A union may seek to represent a combination of the units prescribed by the regulation; the Board's regional directors are authorized to approve stipulations providing for different units; and the rule allows for departures in the case of "extraordinary circumstances" (which are deemed present when application of the regulation would yield a unit containing five or fewer employees). J.A. 260-261.

Reversing a decision by the district court, the court of appeals sustained the regulation against petitioner's claim that it is invalid on its face. Pet. App. 1a-16a.

A. The 1974 Amendments to the National Labor Relations Act

Between 1947 and 1974, the National Labor Relations Act exempted nonprofit hospitals from its coverage. Amendments to the NLRA enacted in 1974 repealed that exemption; Congress found "that improvements in health

care would result from the right to organize, and that unionism is necessary to overcome the poor working conditions retarding the delivery of quality health care." *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 499-500 (1978).

The rights conferred on hospital employees by the 1974 legislation—like those conferred on all other covered employees—include the right "to bargain collectively through representatives of their own choosing." 29 U.S.C. 157. Under Section 9(a) of the NLRA, 29 U.S.C. 159(a), a representative designated or selected for the purpose of collective bargaining by the majority of the employees "in a unit appropriate for such purposes" is empowered to act as the employees' exclusive representative. Section 9(b), 29 U.S.C. 159(b), provides that the Board "shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." That determination is made, in a proceeding conducted in accordance with Section 9(c) of the Act, 29 U.S.C. 159(c), when the Board is called upon to resolve a dispute over recognition of an exclusive bargaining representative.

Although Senator Taft introduced a bill that would have amended the Act to specify five bargaining units for employers in the health care industry,¹ Congress ultimately chose simply to extend the Board's broad authority over bargaining unit determinations to that industry. As part of a compromise that led to passage of the 1974 amendments, however, the following statement—referred to herein as the "admonition"—was included in the committee reports:²

¹ S. 2292, 93d Cong., 1st Sess. (1973). See pp. 35-38, *infra*.

² S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974) (*reprinted in* Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 93d Cong., 2d Sess., *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Rela-*

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 N.L.R.B. No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).*

* By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

B. The Conflict Among the Courts of Appeals over Hospital Bargaining Units

For more than a decade after the 1974 amendments, there were sharp disputes over what bargaining units were appropriate in health care institutions. Although the courts often faulted the Board for failing to heed the admonition, they reached varying conclusions concerning its effect. One group of courts ruled, in substance, that the Board should supplement the "community of interest" approach that had traditionally guided its bargaining unit determinations by also considering whether recognition of a particular unit would be consistent with the admonition.³ The Ninth and Tenth Circuits went farther, ruling that the admonition obligated the Board to adopt a different test—the "disparity of interests" test—

tions Act, 1974, at 8, 12 (Comm. Print 1974) [hereinafter 1974 *Leg. Hist.*]; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974) (reprinted in 1974 *Leg. Hist.* 269, 274-275).

³ E.g., *NLRB v. Mercy Hosp. Ass'n*, 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 633-635 (2d Cir. 1983); *St. Vincent's Hosp. v. NLRB*, 567 F.2d 588 (3d Cir. 1977); *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191, 194 (4th Cir. 1982); *Mary Thompson Hosp. v. NLRB*, 621 F.2d 858, 862-864 (7th Cir. 1980).

calculated to yield broader units.⁴ Finally, after the Board had cited the admonition as a basis for shifting to a disparity of interests test, *St. Francis Hosp.*, 271 N.L.R.B. 948 (1984), the D.C. Circuit held that the Board had erred in concluding that the congressional admonition was an "independent source[] of law" requiring abandonment of the community of interest approach. *International Bhd. of Elec. Workers v. NLRB*, 814 F.2d 697, 715 (1987).

C. The Rulemaking Proceeding

In a notice of proposed rulemaking issued three months after the D.C. Circuit's *IBEW* opinion, the Board candidly described the upshot of these decisions: "Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate units in the health care industry than it was in 1974." J.A. 9; see also J.A. 5. To remedy that situation, the Board initiated a substantive rulemaking proceeding.⁵

1. a. In the *Federal Register* notice initiating the proceeding (J.A. 3-39), the Board outlined the two principal reasons why it had decided to engage in rulemaking. The

⁴ *NLRB v. St. Francis Hosp.*, 601 F.2d 404, 419 (9th Cir. 1979); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 810 (9th Cir. 1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457-458 n.6 (1981), modified sub nom. *Beth Israel Hosp. & Geriatric Center v. NLRB*, 688 F.2d 697 (10th Cir. 1982); *St. Anthony Hosp. Systems, Inc. v. NLRB*, 884 F.2d 518, 521 (10th Cir. 1989).

⁵ In the course of the rulemaking, the Board issued three notices, including two proposed rules and the final regulation, devoting exhaustive attention to a host of issues. Space permits only a brief summary of the Board's treatment of the issues bearing most directly on the questions presented; for the Court's convenience, however, we have appended a table of contents correlating the headings in the notices to the joint appendix's pagination. App., *infra*, 1a-7a.

first was to obtain empirical data on conditions material to bargaining unit determinations. The Board observed that bargaining unit determinations should be calculated to "effectuate section 7 rights by permitting bargaining in cohesive units," while also weighing "Congress's expressed desire to avoid proliferation in order to avoid disruption in patient care, unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages, and increased costs due to whipsaw strikes and wage leapfrogging." J.A. 12. Although noting its own prior "broad generalizations" regarding these matters, the Board acknowledged that "it [had] never obtained empirical data" on them. J.A. 12.

Second, the Board observed, on the basis of its "extensive experience" in bargaining unit adjudications, that groups of employees seeking to exercise their collective bargaining rights "generally exhibit the same internal characteristics and relationship to other groups of employees, in one health care facility as do like groups of employees at other facilities." J.A. 12-13. Thus, the Board continued, "laborious, costly case-by-case record-making and adjudication in this remarkably uniform field has proved to be an unproductive expenditure of the parties' and the taxpayers' funds," and "rulemaking, though perhaps time consuming at the outset, [would] be a valuable long-term investment, paying dividends in the form of predictability, efficiency, and more enlightened determinations as to viable appropriate units, leading ultimately to better judicial and public acceptance." J.A. 14; see also J.A. 46-48, 59-60.

In keeping with the Board's desire for detailed information on conditions in the health care industry, the notice of proposed rulemaking specified a number of issues—regarding "how various bargaining units affect legitimate concerns of both unions and health care employers" (J.A. 19)—on which it hoped to obtain "actual, empirical, practical evidence" (J.A. 20). The Board published a proposed regulation providing for six appropriate bargaining units in acute care hospitals with more than 100

beds, and four appropriate units in acute care hospitals with 100 beds or fewer and in nursing homes. J.A. 37-39.

b. The Board conducted four public hearings, covering 14 days, at three locations and received numerous written comments. In all, it received testimony, both on direct and cross-examination, from 144 witnesses and written comments from 315 individuals and organizations in all sectors of the health care industry. J.A. 42-45. After considering the proposed regulation in open session, the Board issued a second notice of proposed rulemaking. J.A. 40-202. This notice refined the proposed regulation, addressed arguments directed at the Board's authority and the wisdom of proceeding through rulemaking, and explained in detail the justifications for each bargaining unit prescribed by the regulation, as well as other features of the regulation. The Board's stated goal was (J.A. 67)

to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes.

The second notice made various changes in the proposed regulation. The Board eliminated its proposed 100-bed distinction for acute care hospitals, noting that "[t]he vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals." J.A. 162. At the same time, the Board narrowed the regulation to exclude nursing homes and psychiatric hospitals, finding that the characteristics of these facilities, as well as variations among them, made a uniform rule inappropriate. J.A. 165-176.

The Board also modified its initial proposal with respect to units that would be recognized as appropriate for collective bargaining. While the initial proposal provided for six types of units in large acute care hospitals, the modified regulation prescribed eight for all such facilities: registered nurses, physicians, other professionals, technical employees, skilled maintenance employees, business office clerical employees, guards, and other nonprofessional employees. The Board explained in detail its reasons for recognizing each individual unit, canvassing factors common to both the "community of interest" and "disparity of interests" tests. J.A. 91-161; see J.A. 67-68.

The second notice of proposed rulemaking also explained the scope of the regulation's exception for "extraordinary circumstances." J.A. 186-190. The purposes of the exception, the Board said, were to protect parties' due process rights, "to allow for the possibility of individual treatment of uniquely situated acute care hospitals," and "to avoid accidental or unjust application of the rule." J.A. 186-187. To assure that the exception would not provide "an excuse, opportunity, or 'loophole' for redundant or unnecessary litigation and the concomitant delay that would ensue" (J.A. 187), the Board indicated it would construe the exception to foreclose relitigation of issues resolved in the rulemaking (J.A. 187-190; see also J.A. 231 n.5, 244-246).

c. The Board provided a further period for public comment. On April 21, 1989, after considering an additional 1500 comments, the Board published its final regulation accompanied by a further explanatory statement. J.A. 203-262. The final regulation amended the second proposal by specifying that a request for a unit of five or fewer employees would constitute an extraordinary circumstance within that exception to the regulation (J.A. 231-232) and by excluding rehabilitation facilities and drug treatment centers (J.A. 239-240).

2. During the course of the rulemaking, the Board carefully considered and rejected each of the contentions that petitioner advances in this Court.

a. The Board concluded that Section 9(b)'s "in each case" language should not be construed to limit the rulemaking authority conferred by Section 6 of the Act, 29 U.S.C. 156. J.A. 211-215; see J.A. 15-19, 46-48. Application of the regulation at issue was not inconsistent with the Board's obligation to determine an appropriate bargaining unit "in each case," the Board explained, since it would continue to decide the appropriate unit in individual Section 9(c) cases. J.A. 214. The Board noted that it had "long made use of 'rules' of general applicability" formulated in adjudications to determine appropriate units. J.A. 213. It also found support for its position in this Court's decision in *Heckler v. Campbell*, 461 U.S. 458, 467 (1983), and in cases and commentary stressing the advantages of rulemaking. J.A. 15-18, 46-48, 213-218 & n.2.

b. Although the Board observed in its final notice that it was "inclined to agree" with the D.C. Circuit's conclusion that the congressional admonition did not impose a binding obligation on the Board (J.A. 247-248), the Board was "mindful of avoiding undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry" (J.A. 66; see J.A. 25-26). Accordingly, in justifying the units prescribed by the regulation, the Board expressly determined that both the particular units specified and the scheme as a whole were consistent with the congressional admonition. J.A. 114, 120, 122, 131, 140-141, 145-146, 158-159, 191-194, 246-254.

c. The Board acknowledged that there were variations among hospitals (J.A. 49-50), but viewed the "relevant question" as "whether, despite surface differences, there are such similarities that certain institutions may properly be grouped as a class" (J.A. 53). After analyzing claims that changes in the industry, differences among hospitals, cost pressures, and hospitals' need for flexibility foreclosed a uniform rule (J.A. 56-59), the Board found that "[s]uch diversity as exists has not been shown to be sufficiently significant to preclude uniform treatment

for purposes of establishing the general contours of appropriate bargaining units for acute care hospitals in all but truly extraordinary facilities" (J.A. 57-58). In justifying particular units, moreover, the Board cited particular circumstances warranting similar treatment of categories of employees in all but exceptional acute care hospitals. *E.g.*, J.A. 93-94, 97, 98, 101 (nurses); J.A. 125, 131-132 (technical employees); J.A. 137, 144, 153, 155 (skilled maintenance employees).⁶

D. Proceedings in the Lower Courts

1. Petitioner challenged the regulation on its face in a suit filed in the United States District Court for the Northern District of Illinois. Although the district court concluded that the "in each case" language of Section 9(b) did not prohibit the regulation (Pet. App. 35a), it ruled that the admonition in the legislative history of the 1974 amendments required the Board to "use the means least likely to cause unit proliferation to achieve [its] objective" (*id.* at 38a). Observing that it could "envision other divisions, perhaps fewer divisions, in the varied health institutions which would be [as] reasonable" as the units the Board had chosen, the court concluded that the regulation was inconsistent with the admonition and enjoined its implementation. *Id.* at 38a, 41a-42a.

2. The court of appeals reversed. Pet. App. 1a-16a. It rejected petitioner's contention that the "in each case" language of Section 9(b) precluded the Board's regulation. Finding "no reason why Congress might have wanted to carve out unit determinations from the grant of rulemaking power in section 6 and no indication beyond the ambiguous semantics of the word 'case' that it did want to do this," the court concluded "that unit de-

⁶ Board Member Johansen dissented from the orders issuing the second proposed regulation and the final regulation. J.A. 198-202, 255-258. He concluded that the "in each case" language in Section 9(b) of the Act foreclosed establishing bargaining units through rulemaking and that rulemaking was not necessary or desirable in any event.

terminations [are] not excepted from the Board's power under that section." Pet. App. 8a.

The court of appeals also held that the regulation was consistent with the 1974 admonition. The court concluded that the admonition "is entitled to our respectful consideration," but is "not an amendment to section 9(b), decreeing that in the health-care industry no more than three separate bargaining units shall be authorized" (Pet. App. 12a). "[E]ven if [the admonition] were a statute" (*ibid.*), the court continued, Congress's concern had focused on "finer divisions of the health-care work force than attempted in the rule under challenge" (*id.* at 14a), and nothing in the admonition "reads on the issue of the propriety of eight units" (*id.* at 13a).

Finally, the court rejected petitioner's contention that the Board's regulation "is arbitrary because it lumps together hospitals of different sizes and missions in different locations" (Pet. App. 14a). The court observed that the very nature of a regulation is to make "one or a few of a mass of particulars legally decisive, ignoring the rest"; the "result is a gain in certainty, predictability, celerity, and economy, and a loss in individualized justice" (*id.* at 15a). Finding that the Board "did a responsible job of weighing the conflicting arguments" (*id.* at 16a), the court of appeals upheld the regulation.

SUMMARY OF ARGUMENT

One of the great strengths of the administrative process is that agencies are able, through the promulgation of rules, to narrow and define the scope of the issues for adjudication. The regulation challenged in this case is an example of the working of this process at its best. It should not be set aside by adopting the petitioner's strained construction of the National Labor Relations Act, by giving unwarranted meaning and weight to a fragment of legislative history, or by failing to recognize the firm foundation for the Board's findings and conclusions.

1. The challenged regulation is consistent with Section 9(b) of the NLRA. The statutory direction to the Board

—to “decide in each case * * * the unit appropriate for the purpose of collective bargaining”—is a direction to conduct individual unit determination proceedings whenever a question of representation is properly presented. It is not in any sense a restriction on the Board’s authority to formulate rules of decision to narrow and define the scope of the issues in those proceedings. It is not, in short, a requirement that every representation proceeding must be treated as a case of first impression.

Section 9(b) is a broad grant of discretion to the Board to determine appropriate bargaining units. But a grant of broad discretion is in no way inconsistent with the use of rulemaking authority to implement an agency’s judgment that an issue should be resolved one way in a class of cases. *Heckler v. Campbell*, 461 U.S. 458 (1983); *Fook Hong Mak v. INS*, 435 F.2d 728 (2d Cir. 1970) (Friendly, J.). That is precisely what the Board has done here.

The “in each case” language, so heavily relied on by petitioner, does not invalidate this exercise of the Board’s authority. The language was added to the 1935 Act as a clarifying amendment to insure that application of the governing rules will occur in a decision tailored to the particular case—a decision following a proceeding in which the parties are able to raise all relevant questions about the proper application of those rules. There is no basis whatever in the language or history of the amendment for the far more radical, and destructive, reading advocated by petitioner. Moreover, petitioner’s reading is inconsistent with the Board’s practice over the years of adopting rules of decision to govern in unit determination cases. Nor can petitioner’s reading be squared with this Court’s interpretation of the scope of agency authority under other, similar statutes.

2. The Board’s rule is fully consistent with the 1974 amendments to the NLRA. Petitioner’s heavy reliance on the admonition in the committee reports accompanying that legislation is misplaced. The admonition is perhaps most significant as the residue of what Congress

failed to include in the statute—despite the best efforts of petitioner and others. And in any event, it in no way changes the character of the Board’s authority under Section 6 to promulgate rules of decision designed to narrow and define the issues in representation proceedings.

Moreover, whatever requirements may be imposed on the Board by the admonition were fully satisfied in this proceeding. At the outset of the rulemaking, the Board sought answers to empirical questions bearing on the potential evils of undue proliferation of bargaining units, and then exhaustively analyzed the data received in its explanation of its revised proposal. In that statement, the Board explained in detail why neither the regulation as a whole nor any of the individual units prescribed would contribute to those evils or otherwise run afoul of the admonition.

3. The regulation is not arbitrary, capricious, or an abuse of discretion. The standard of review is one that requires deference to the Board’s analysis and expertise, but the Board’s exhaustive consideration of the materials presented, and its careful explanation of the basis for its action, would survive attack even under a far more rigorous standard. Petitioner’s effort to attack the regulation as an unexplained departure from prior Board rulings fails both because it mischaracterizes many of those rulings and because the Board has fully explained the basis for those changes in policy that the regulation does embody. And petitioner’s challenge to the regulation on the ground that the Board has overlooked significant variations among health care institutions also fails. The Board did take account of those variations it regarded as material, and it fully justified its conclusion that other variations do not require disparate treatment of acute care hospitals in unit determination proceedings.

ARGUMENT

I. THE HOSPITAL BARGAINING UNIT REGULATION IS CONSISTENT WITH SECTION 9(b) OF THE NATIONAL LABOR RELATIONS ACT

Since 1935, the Board has conducted proceedings to determine whether an employer is required to recognize a collective bargaining representative for a group of employees. At present (see note 17, *infra*), Section 9(c) of the NLRA, 29 U.S.C. 159(c), permits employees, labor organizations, and employers to file petitions seeking such a determination. In the ensuing proceeding, the Board decides, among other issues, whether the unit proposed in the petition, or some other unit, is an appropriate unit for collective bargaining.

Section 9(b) supplies the basic standard for those determinations; it directs the Board to "decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." In this case, the Board has employed its statutory rulemaking authority to give specificity to that standard in its application to a particular category of employers—acute care hospitals. Because it is the Board's judgment that "acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units" (J.A. 189), the regulation is expressed in terms of the units that, in the absence of extraordinary circumstances, will be recognized as appropriate for that group of employers. The issue here is whether Section 9(b)'s "in each case" language precludes this exercise of the Board's rulemaking power. The question, in other words, is whether those three words require significant curtailment of one of the major advantages of the administrative process—the ability of an agency to narrow and define the scope of issues through the promulgation of rules.

In the explanatory statement accompanying the Final Rule, the Board took care to explain why it believed the "in each case" language imposed no such limitation on its rulemaking power. J.A. 214; see J.A. 15-17, 47, 212-215. The Board reasoned (J.A. 214):

There is nothing inconsistent between section 9(b) and the Board's use of its APA rulemaking power. Section 9(b) requires the Board to decide the appropriate unit in each case, and the Board will continue to do so under this rule. Should the parties not agree on the appropriate unit, a hearing in each case will still be directed, with the Board ultimately rendering a decision on the appropriate unit applicable to that particular petition and that particular employer's operation. The Board may properly rely on a rule properly promulgated under the APA just as it has, since 1935, relied on rules formulated under adjudication.¹⁷

In response, petitioner has not contended—and indeed could not contend—that the Board can *never* employ its rulemaking power to elaborate the standard set forth in Section 9(b). Petitioner concedes that the Board would have authority to issue "rules establishing general principles to guide the required case-by-case bargaining unit determinations," including at least "regulations stating the factors regional directors should weigh in determining bargaining unit appropriateness" (Pet. Br. 19) and perhaps "rebuttable presumption[s] of fact" (*id.* at 21). Yet, without ever making clear just what limitation it finds in the words "in each case," petitioner maintains that the Board's regulation is too "rigid" in prescribing appropriate units.⁸

⁷ As the Board noted, a range of issues, such as whether an institution is an acute care hospital under the rule, will be subject to determination in each proceeding under Section 9(c). J.A. 215-216 n.2; note 14, *infra*.

⁸ Most of petitioner's argument is structured around the dichotomy it perceives between "individual case-by-case determinations of bargaining units" and what it characterizes as "rigid," "in-

The Board's interpretation of Section 9(b) is fully justified by the language, structure, and legislative history of the statute, the Board's past practice, and decisions of this Court construing analogous statutes. Moreover, even if there were another reasonable interpretation, the Board's interpretation is at least "rational and consistent with the statute" and thus deserving of deference from this Court. *E.g.*, *NLRB v. United Food Workers Union, Local 23*, 484 U.S. 112, 123 (1987). See *INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987); *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 & n.9 (1984). By contrast, petitioner's interpretation is untenable. The words "in each case" cannot reasonably be interpreted to prohibit the Board from concluding, on the basis of its study and experience, that variations among a discrete class of employers are not sufficient to require them to be treated differently in unit determination proceedings.

A. The "In Each Case" Language Does Not Limit the Board's Authority to Promulgate Regulations Applicable in Representation Proceedings

On their face, the words "in each case" refer to the proceeding in which the Board is to issue its bargaining unit determinations, and not to the nature of the rules or principles that may be brought to bear in those proceedings or to the evidence that may or must be considered. Thus, the directive to the Board to "decide [the scope of the appropriate unit] in each case" is most

flexible," or "set" rules (see, *e.g.*, Pet. Br. 11, 13, 14, 15, 17). The dichotomy is false; worse, it is a veiled invitation to engage in excessive review of administrative judgments. The application of rules in a particular case is a routine element of case-by-case adjudication. Rules are most effective in assuring the consistency and efficiency of adjudications when they provide as much certainty as the considerations underlying them justify. In the administrative context, agencies have primary responsibility for fashioning such rules; courts review the rules to determine whether they are within the scope of an agency's authority and whether they are arbitrary and capricious.

plausibly read simply to require the Board to render its bargaining unit determinations in each individual representation proceeding, employing whatever rules and procedures are otherwise proper. The statutory context—the provisions of the Act empowering the Board to issue rules and to make bargaining unit determinations—confirms that interpretation.

1. The NLRA charges the Board with "primary responsibility for developing and applying national labor policy," *e.g.*, *NLRB v. Curtin Matheson Scientific, Inc.*, 110 S. Ct. 1542, 1549 (1990). To that end, Section 6 of the Act, 29 U.S.C. 156, authorizes the Board "to make * * * such rules and regulations as may be necessary to carry out the provisions of [the Act]." That rulemaking authority includes the power to elaborate on the broad provisions of the NLRA. If the Board "is to accomplish the task which Congress set for it, [it] necessarily must have authority to formulate rules to fill the interstices of broad statutory provisions." *Beth Israel Hosp. v. NLRB*, 437 U.S. at 501. In its adjudications, the Board has often announced, and this Court has upheld, rules of decision elaborating on the NLRA.⁹ Unless the "in each case" language limits the Board's power in the context of bargaining unit determinations, the Board has equivalent authority to specify, as to particular classes of employers, what bargaining units will "assure to employees the fullest freedom in exercising the rights guaranteed [by the Act]." 29 U.S.C. 159(b).

Whether promulgated in adjudications or through rulemaking, rules adding specificity to the Act, and thus nar-

⁹ *Charles D. Bonnano Linen Service, Inc. v. NLRB*, 454 U.S. 404 (1982); *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969); *Brooks v. NLRB*, 348 U.S. 96 (1954); *Republic Aviation Corp. v. NLRB*, 324 U.S. 793 (1945). See *NLRB v. Burns Int'l Security Servs., Inc.*, 406 U.S. 272, 290 n.12 (1972). As long as it complies with procedural requirements, the Board has discretion to employ either rulemaking or adjudications to add specificity to the Act. See *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 292-294 (1974); *NLRB v. Wyman-Gordon Co.*, *supra*; cf. *SEC v. Chenery Corp.*, 332 U.S. 194 (1947).

rowing the issues for adjudication, serve important statutory policies. Rules provide guidance to private parties, channel the exercise of the Board's discretion, and add efficiency and consistency to the Board's adjudications.¹⁰ Those advantages of rulemaking have particular force in the context of bargaining unit determinations. Rules settling the scope of appropriate bargaining units allow employees to plan organizational campaigns to reach members of an appropriate bargaining unit and enable employers to determine whether they have a legitimate basis for opposing a request for recognition.¹¹ Conversely, litigation arising from uncertainty over appropriate bargaining units burdens the Board's processes, frustrates the exercise of rights protected by the Act, and encourages employers to use delaying tactics to diminish the union's support. See J.A. 52. Many courts and commentators—emphasizing the certainty and information-gathering advantages of rulemaking—have urged the Board to make greater use of its power to issue regulations in this area.¹²

¹⁰ See generally Bernstein, *The NLRB's Adjudication-Rule Making Dilemma Under the Administrative Procedure Act*, 79 Yale L.J. 571, 587-598 (1970); Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 Harv. L. Rev. 921, 929-942 (1965); Peck, *The Atrophied Rule-Making Powers of the National Labor Relations Board*, 70 Yale L.J. 729, 734-735 (1961); Morris, *The NLRB in the Dog House—Can an Old Board Learn New Tricks?*, 24 San Diego L. Rev. 9, 29-42 (1987). See also *NLRB v. Wyman-Gordon Co.*, 394 U.S. at 777-778 (Douglas, J., dissenting); Scalia, *The Rule of Law As A Law Of Rules*, 56 U. Chi. L. Rev. 1175, 1179 (1989).

¹¹ For this reason, some hospitals supported the concept of rulemaking before the Board, maintaining that "unit determinations in the industry were confused and hard to follow" and led to "protracted litigation." J.A. 51.

¹² See, e.g., *Continental Web Press, Inc. v. NLRB*, 742 F.2d 1087, 1093-1094 (7th Cir. 1984); *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1466 (7th Cir. 1983); *Trustees of Boston Univ. v. NLRB*, 575 F.2d 301, 305 (1st Cir. 1978); J.A. 17-18 nn.33-35; Pet. App. 5a-6a. See also note 10, *supra*.

2. Section 9(b) cannot fairly be construed to subtract, by implication, from the Board's power to employ rulemaking to enhance the certainty, consistency, and efficiency of bargaining unit determinations. As this Court has noted, Section 9(b) provides the Board with "broad discretion" to determine appropriate bargaining units, e.g., *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947). In exercising that discretion, the Board is not required to apply the statutory standard to the facts of each case as if it were a case of first impression. Rather, the Board is free to articulate the basis for its decisions "by reference to other decisions or its general policies laid down in its rules and its annual reports, reflecting its 'cumulative experience.'" *NLRB v. Metropolitan Life Ins. Co.*, 380 U.S. 438, 443 n.6 (1965). "The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding 'in each case' are classifications, rules, principles, and precedents." K. Davis, *Administrative Law Text* 145 (3d ed. 1972).

There is no inconsistency between the Act's grant of "wide discretion" to the Board, recognizing its "need for flexibility," *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944), and the adoption of rules applying to a particular category of employers.¹³ As Judge Friendly noted in a much-quoted decision, there is no general principle "forbidding an administrator, vested with discretionary power, to determine by appropriate rulemaking that he will not use it in favor of a particular class on

¹³ Contrary to petitioner's assertion (Pet. Br. 17), this Court has never indicated "that the statute required case-by-case determination of bargaining-unit appropriateness and precluded reliance on the kind of inflexible rules the Board has now issued." None of the cases cited for that proposition, *NLRB v. Hearst Publications, Inc.*, 322 U.S. at 134; *NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985); *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947), called upon the Court to consider the extent of the Board's power to apply rules to bargaining unit determinations; thus, the Court expressed no position on that issue.

a case-by-case basis, if his determination is founded on considerations rationally related to the statute he is administering." *Fook Hong Mak v. INS*, 435 F.2d 728, 730 (2d Cir. 1970). So here, Congress wisely conferred on the Board broad discretion to frame bargaining units, but at the same time empowered the Board to adopt more specific rules narrowing its discretion when it determines that the members of a particular class or category are sufficiently alike to be treated alike.

3. The Board's interpretation—which recognizes its obligation to issue bargaining unit determinations in each individual representation proceeding and its authority to "rely on a rule properly promulgated under the APA" (J.A. 214) in making those determinations—is the most plausible reading of "in each case" and also affords full effect to the Board's authority under both Sections 6 and 9 of the Act. There is no merit to petitioner's suggestion (see Pet. Br. 19) that a larger role—and one that substantially impairs the Board's authority—must be found for the "in each case" language.

First, the Board's interpretation of the "in each case" language is consistent with the view of its drafters that it constituted a clarifying amendment (see pp. 21-23, *infra*). Petitioner's view, which would work a radical reduction of the Board's authority, far transcends clarification. Second, the "in each case" language does serve important functions under the Board's interpretation. It assures that the results of the application of the rule to the material facts will be expressed in a decision tailored to the individual case. The Board's interpretation also guarantees that the rule will be applied to the parties to a representation dispute in a proceeding in which they will have the opportunity, before the agency and upon judicial review, to raise questions as to how the rule applies to particular facts, to argue that the rule does not apply at all, and to raise questions unrelated to the rule.¹⁴ The "in each case" language occupies a

¹⁴ Such questions include, for example, not only whether there are "extraordinary circumstances," but also whether a contract bar

meaningful place in the statute; there is no warrant for reading it as a limit on the Board's use of rules of decision.¹⁵

B. The Board's Interpretation Is Consistent With the Legislative History of the "In Each Case" Language

The words "in each case" did not initially appear in the bill introduced by Senator Wagner from which the NLRA evolved.¹⁶ The Senate Labor Committee inserted the phrase at the suggestion of Secretary of Labor Frances Perkins, whose explanation of the amendment was terse. She observed only that a number of amendments—of which "in each case" was just one—were "for the sake of clarity." 1 *1935 Leg. Hist.* 1332, 1442, 1445; 2 *id.* at 2757-2758. Likewise, the Senate committee that added the "in each case" language evidently did not con-

exists, whether a single- or multiple-facility unit is required, whether an institution is an "acute care hospital," whether particular employees are supervisors, whether given employees should be placed in a particular unit, how to treat an employee with "dual" functions, and whether a union's proposal for a combination of units is appropriate. See J.A. 123 n.23, 132, 149, 160, 186, 216 n.2, 225-226, 231, 243.

¹⁵ Four of the five court of appeals decisions on which petitioner relies (Pet. Br. 17-18 n.6) held that Section 9(b) prohibits the Board from effectively delegating its obligation to determine bargaining units to state agencies. *Memorial Hosp. v. NLRB*, 545 F.2d 351 (3d Cir. 1976); *NLRB v. Cardox Div. of Chemetron Corp.*, 699 F.2d 148 (3d Cir. 1983); *Allegheny General Hosp. v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *Long Island College Hosp. v. NLRB*, 566 F.2d 833 (2d Cir. 1977), cert. denied, 435 U.S. 996 (1978). Cf. *NLRB v. Pittsburgh Plate Glass Co.*, 270 F.2d 167, 173-174 (4th Cir. 1959) (holding that Board had erred in effectively delegating authority to employees), cert. denied, 361 U.S. 943 (1960). The fifth upheld the Board's use of a rebuttable presumption; the court's observations as to the permissibility of an irrebuttable presumption were dicta. *Big Y Foods, Inc. v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981).

¹⁶ S. 1958, 74th Cong., 1st Sess. (1935) (reprinted in 1 *NLRB Legislative History of the National Labor Relations Act of 1935*, at 1300 (1949) [hereinafter *1935 Leg. Hist.*]).

sider it important enough to warrant an explanation in the committee report. S. Rep. No. 573, 74th Cong., 1st Sess. 14 (1935), *reprinted in 2 1935 Leg. Hist.* 2313.

Consequently, the legislative history does not pinpoint the uncertainty that the Perkins amendment was calculated to eliminate.¹⁷ The "in each case" language may be related to a suggestion advanced by John Frey, President of the Metal Trades Department of the American Federation of Labor, in testimony before the Senate Labor Committee in support of S. 1958. He proposed adding the words "in each instance" to Section 9(b) to make clear that "when a specific case comes to the Board, in the individual case the Board will decide which shall be the unit of representation * * *." 1 *1935 Leg. Hist.* 1583; see *id.* at 1334. This statement is consistent with the Board's interpretation.

Subsequent House committee reports included a similar statement that the "matter [of appropriate bargaining units] is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination." H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935) (*reprinted in 2 1935 Leg. Hist.* 2930); H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935) (*reprinted in 2 1935 Leg. Hist.* 2976); H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935) (*reprinted in 2 1935 Leg. Hist.* 3072). While petitioner places great stress on these statements (Pet. Br. 14), they are not

¹⁷ In assessing the significance of the Perkins amendment, it is important to recall that the Board's procedures for representation proceedings were novel and were not finally settled until, after the enactment of the Wagner Act, the Board issued a rule providing for the submission of representation petitions. See J. Rosenfarb, *The National Labor Policy and How it Works* 301, 303-304 (1940). Section 9(c) of the Wagner Act, ch. 372, 49 Stat. 453, was substantially amended in 1947; as enacted in 1935, it did not refer to representation petitions. In 1935, the addition of "in each case" to Section 9(b) could well have been regarded as a clarification of the fact that the Board would determine an appropriate bargaining unit in each case in which its processes were invoked.

at all inconsistent with the Board's position here. If the regulation at issue is upheld, the Board will continue to determine bargaining units by applying the regulation and considering all other issues "in each individual case." Nothing in the legislative history suggests that the amendment was to have the extraordinary effect of restricting the Board's authority to narrow and define the issues through adoption of rules.¹⁸

C. From Its Earliest Days, the Board Has Adopted Rules of Decision to Guide its Bargaining Unit Determinations

As petitioner notes (Pet. Br. 16), the regulation at issue is the product of the first rulemaking the Board has undertaken in this area. That is not to say, however, that the Board previously construed the statute to withhold authority to fashion rules to limit and structure its bargaining unit determinations. Indeed, from its inception, the Board has announced rules of decision narrowing the issues in particular categories of bargaining unit cases when, in its judgment, those categories have warranted that treatment.¹⁹

¹⁸ Petitioner's reliance (Pet. Br. 15-16) on testimony by Francis Biddle to the effect that "[i]t is impossible to lay down a definite rule for the determination of the appropriate unit" (1 *1935 Leg. Hist.* 1459) is misplaced. Mr. Biddle was discussing the form of the legislation that Congress should draft, not the rules the Board might adopt. In this respect, Mr. Biddle's testimony was consistent with the statement by the "first NLRB" (an agency of which Mr. Biddle was the Chairman, operating under authority of an Executive Order for a brief period prior to the enactment of the Wagner Act) that the choice of a bargaining unit was "an administrative matter" (see Pet. Br. 15).

¹⁹ Petitioner argues (Pet. Br. 16) that the Board, in its First Annual Report, "explained that Congress required [it] to determine the appropriate bargaining unit individually in each particular case and precluded adoption of rigid rules." What the Board actually said was:

Experience has proven the wisdom of delegating to the Board the task of deciding in each case the unit appropriate for purposes of collective bargaining. The complexity of mod-

1. From the outset, it has been the Board's practice to supplement the statutory standard with its own, more specific, pronouncements. The First Annual Report outlined factors—nowhere mentioned in the statute—to which the Board referred in making bargaining unit determinations. NLRB, *First Ann. Rep.* 113 (1936). More specific rules were announced over time. In 1938, the Board reported that “[i]n a limited number of situations, the Board has found that it can formulate rules which apply in the absence of factors tending to make them inapplicable”; as an example, it cited a decision in which it had held that “clerical employees, engineers, and chemists are prima facie unsuitable for inclusion in a unit with production employees.” NLRB, *Third Ann. Rep.* 159-160 (1938).

In 1945, the Board reported (*Tenth Ann. Rep.* 35 (1945)):

In considering a large number of cases which are apparently symptomatic of the spread of union organization among white collar workers, the Board has developed certain additional rules which are generally applied, in the absence of persuasive reasons

ern industry, transportation, and communication, and the numerous and diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case.

NLRB, *First Ann. Rep.* 112 (1936). As a reading of this passage shows, the Board was approving the breadth of discretion given it by Congress, and also indicating its own disapproval of “rigid rules.” The Board was not acknowledging any statutory preclusion of its authority to adopt rules narrowing its own discretion when, in the Board's judgment, conditions justified that course.

The point was repeated in the Board's subsequent reports through 1942. A statement in that year's Seventh Annual Report did refer to the Board's “duty under the Act”—to “decide[] each case on the basis of all the facts and circumstances involved.” NLRB, *Seventh Ann. Rep.* 59 (1942). But this single statement in an annual report, whatever its intent, must be considered against the background, discussed in text, of the Board's frequent adoption of rules of decision narrowing and defining the scope of its discretion.

to the contrary: office clerical and technical workers are normally segregated from production and maintenance workers, and technical workers are usually segregated, in turn, from clerical employees if any interested party argues for their separation; but plant clericals who work in close contact with production workers and under the same supervision with them, are treated as part of the production and maintenance group.

See *Kroger Co.*, 204 N.L.R.B. 1055 (1973); *Westinghouse Elec. Corp.*, 118 N.L.R.B. 1043, 1047 & n.12 (1957).²⁰

Other rules, like the regulation at issue, were formulated with reference to conditions in particular industries. For instance, in *E.H. Koester Bakery*, 136 N.L.R.B. 1006, 1009-1012 (1962), the Board noted that it assigned truck drivers in a few industries, where generalizations were possible, to a combined unit or to a separate unit on an industry-wide basis, but resolved their treatment in the remaining industries by reference to various factors. The Board has also evolved principles regarding the breadth of bargaining units in various industries. There is a presumption in favor of single-plant or single-outlet units in most industries, in favor of district-office units in the insurance industry, and in favor of systemwide units in the public utility and oceanic transport industries. 1 C. Morris, *The Developing*

²⁰ In 1947, some of the Board's rules of decision—regarding professionals, supervisory personnel, and craft severance—were a major bone of contention in the debates leading to the enactment of the Taft-Hartley Act. Congress amended Section 9 to supply additional statutory standards for bargaining unit determinations in those areas. 29 U.S.C. 159(b)(1)-(3) and (c)(5). But Congress did not suggest that the Board should cease its efforts to formulate rules of decision. To the contrary, the Senate committee report observed that “[i]n view of the tremendous number of [unit determination] cases, * * * it is of utmost importance that the regulations and rules of decision by which they are governed be drawn so as to insure to employees the fullest freedom of choice.” NLRB, *Legislative History of the Labor Management Relations Act, 1947*, at 416 (1948).

Labor Law 432-436 (2d ed. 1983). These examples of Board rules of decision are not exhaustive.²¹

2. Petitioner thus paints a misleading picture of the Board's past practice.²² While the dominant feature of its bargaining unit determinations has been the "community of interest" approach, the Board has, from time to time, announced specific rules applicable to particular groups of employees or industries. The present regulation leaves less leeway for exceptions than many of the rules previously established, but their effect is much the same. A party seeking to establish the propriety of a unit combining clerical and production workers who fails to show "persuasive reasons" for that unit (pp. 24-25, *supra*) is in essentially the same position as an acute care hospital that is unable to demonstrate "extraordinary circumstances." Thus, the Board was fully justified in viewing the regulation at issue as a logical extension of its past practice of enunciating rules in bargaining unit cases. See J.A. 213-214.²³

²¹ See, e.g., *Esco Corp.*, 298 N.L.R.B. No. 120 (June 20, 1990) (setting forth three conditions for separate retail warehouse unit).

²² In *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980), the Board acquiesced in a decision by the Ninth Circuit holding that an "irrebuttable presumption" in favor of a separate nurses unit, based upon the record in a prior adjudication, was inconsistent with Section 9(b) and the 1974 admonition. See *NLRB v. St. Francis Hosp.*, 601 F.2d 404 (9th Cir. 1979). It is by no means clear that the Board would have considered the regulation at issue here, which is based upon a detailed rulemaking record and includes an exception for "extraordinary circumstances," as the equivalent of the "irrebuttable presumption" at issue in *Newton-Wellesley*. But in any event, the Board's present interpretation, which is based on an exhaustive consideration of new data, as well as on full discussion of relevant precedent, is entitled to deference. See *Chevron U.S.A. Inc. v. NRDC, Inc.*, 467 U.S. at 863-864; *American Trucking Ass'n, Inc. v. Atchison, T. & S.F. R.R.*, 387 U.S. 397, 416 (1967).

²³ In any event, "[a]uthority actually granted by Congress * * * cannot evaporate through lack of administrative exercise." *FTC v. Bunte Bros.*, 312 U.S. 349, 352 (1941). See *United States v. E.I. duPont de Nemours & Co.*, 353 U.S. 586, 590 (1957).

D. The Board's Interpretation Finds Further Support in Decisions of this Court Construing Analogous Statutory Schemes

The Board's view of its authority under Sections 6 and 9(b) is consistent with decisions of this Court addressing analogous statutory schemes. *Heckler v. Campbell*, 461 U.S. at 467; *FPC v. Texaco Inc.*, 377 U.S. 33, 41-44 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). See also *FCC v. WNCN Listeners Guild*, 450 U.S. 582, 600-601 & n.44 (1981). In each of these cases, this Court rejected a contention that a statutory provision requiring an individualized determination limited an agency's broad grant of rulemaking authority.

In *Heckler v. Campbell*, for instance, a person claiming disability benefits—which were available upon a showing that the claimant was unable to engage in substantial gainful employment in the economy—argued that a provision entitling her to a hearing should be construed to prohibit HHS from adopting rules specifying the employment available for persons with various impairments. The Court rejected that contention, explaining (461 U.S. at 467 (citations omitted)):

It is true that the statutory scheme contemplates that disability hearings will be individualized determinations based on evidence adduced at a hearing. * * * But this does not bar the Secretary from relying on rulemaking to resolve certain classes of issues. The Court has recognized that even where an agency's enabling statute expressly requires it to hold a hearing, the agency may rely on its rulemaking authority to determine issues that do not require case-by-case consideration. A contrary holding would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding.²⁴

²⁴ As the Court noted in *Heckler v. Campbell*, the affected party was permitted to show that the contested rule should not be ap-

The same reasoning is applicable here. Section 9(b)'s requirement that the Board issue its bargaining unit determinations "in each case" is functionally indistinguishable from the provisions that, in *Heckler v. Campbell*, required "individualized determinations based on evidence adduced at a hearing." Compare Pet. Br. 21. Petitioner mistakenly attempts (*id.* at 22-23) to distinguish *Heckler v. Campbell* on the basis that the regulations in that case addressed an issue "not unique to each claimant" (461 U.S. at 468). Here, the Board has determined that acute care hospitals are sufficiently alike to be treated alike—that variations among them do not present issues so unique to those hospitals as to require different treatment. J.A. 57-58, 189. Because the Board's rulemaking authority includes the power to determine which issues require individual treatment and which "may be established fairly and efficiently in a single rulemaking proceeding," a court may not displace that judgment unless it is beyond the scope of the Board's authority or is arbitrary and capricious.²⁵ Nothing in *Heckler v. Campbell* suggests otherwise.

plied to her (461 U.S. at 467 & n.11). The "extraordinary circumstances" exception to the Board's regulation affords parties to representation proceedings a comparable opportunity. See J.A. 21, 186-190, 244-246. See also *FCC v. WNCN Listeners Guild*, 450 U.S. at 601 n.44 (suggesting that such a "safety valve" is not invariably necessary).

²⁵ See Pet. App. 16a ("The decision how much discretion to eliminate from the decisional process is itself a discretionary judgment, entitled to broad judicial deference.").

E. The Board's Regulation Is Consistent with Any Reasonable Interpretation of the "In Each Case" Language

For the reasons stated, the Board's interpretation of the "in each case" language is more than just "rational and consistent with the statute" (*NLRB v. United Food Workers Union, Local 23*, 484 U.S. at 123); it best accommodates the language, structure, and legislative history of the NLRA and other relevant materials. That interpretation should therefore be upheld by this Court.

Moreover, the regulation at issue does not operate to deprive acute care hospitals of meaningful consideration of facts *material* to the Board's bargaining unit determinations. Unless the Board is to be relegated to receiving whatever evidence a party wishes to offer, the Board must be allowed to define the issues material to its determinations and to exclude evidence on issues that cannot affect its judgments. See *FPC v. Texaco Inc.*, 377 U.S. at 44; *Fook Hong Mak v. INS*, 435 F.2d 728 (2d Cir. 1970).

Significantly, although petitioner never alludes to it, the Board and the courts have consistently held that Section 9(b) requires the Board only to designate *an* appropriate unit, not the most appropriate unit.²⁶ Thus, a regulation that is based on the Board's assessment of conditions in a discrete sector of an industry, that adds efficiency and consistency to the Board's decisions, and that facilitates the exercise of protected rights may not be

²⁶ See, e.g., *Morand Brothers Beverage Co.*, 91 N.L.R.B. 409, 417-418 (1950), enforced on other grounds, 190 F.2d 576 (7th Cir. 1951); *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 634 (2d Cir. 1983); *State Farm Mutual Auto Ins. Co. v. NLRB*, 411 F.2d 356, 358 (7th Cir.) (en banc), cert. denied, 396 U.S. 832 (1969); *Friendly Ice Cream Corp. v. NLRB*, 705 F.2d 570, 574-575 (1st Cir. 1983); *Local 627, Operating Engineers v. NLRB*, 595 F.2d 844, 848-849 (D.C. Cir. 1979); *NLRB v. Western & Southern Life Ins. Co.*, 391 F.2d 119, 123 (3d Cir. 1968), cert. denied, 393 U.S. 978 (1969).

rejected by a court because it excludes consideration of particular facts tending to show that some configuration other than that specified in the rule might be "better" in the particular case.²⁷

The regulation at issue here represents the Board's "considered judgment * * * that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units" (J.A. 188-189; see J.A. 57-58) and, accordingly, that "the issue of the scope of the appropriate unit within an acute care hospital does not generally require adjudicatory consideration" (J.A. 216 n.2). Consistent with this judgment, the regulation does not permit an acute care hospital to relitigate, in an individual proceeding, the Board's decision that certain facts will not result in a decision that a unit is inappropriate. Rather, the claimant is limited to presenting evidence on facts that are potentially material, a limitation that includes an opportunity to show "extraordinary circumstances" warranting a departure from the regulation (J.A. 215-216 n.2, 244-246; note 14, *supra*).²⁸

²⁷ For that reason, petitioner is misguided in suggesting that the effect of the regulation at issue is to impose a bargaining unit on the parties "even when the facts are to the contrary" (Pet. Br. 21). Here, the Board has determined that—absent extraordinary circumstances—the facts that might be offered to contradict the units prescribed by the regulation would not show that a prescribed unit was other than an appropriate unit. This action involves a *facial* challenge, see *Bowen v. Yuckert*, 482 U.S. 137, 154 & n.12 (1987), but petitioner makes no effort to demonstrate that, on its face, the regulation fails to produce units that "assure to employees the fullest freedom in exercising [their] rights." 29 U.S.C. 159(b).

²⁸ The exception is not, as petitioner contends (Pet. Br. 20), "illusory." It may not be employed to relitigate issues—such as the size of a given institution, the services it offers, certain staffing patterns, and a variety of other circumstances (J.A. 187-188, 216)—that were determined in the rulemaking to be immaterial. But the exception applies when application of the rule would yield a unit of five or fewer employees and "remains available * * * for any party who wishes to argue for any reason that the rule should not be applicable to its facility" (J.A. 231 n.5). A party is free

II. THE BOARD'S RULE IS CONSISTENT WITH THE 1974 AMENDMENTS TO THE NLRA

Petitioner places great reliance on the admonition in the 1974 committee reports. But evidently recognizing the difficulty it faces in deriving a legal obligation from a statement in committee reports, petitioner attempts to merge the question whether the regulation violates the "in each case" language with the separate question whether the regulation violates the admonition. Petitioner argues, for instance, that the admonition "confirm[s]," "underscore[s]," or "reaffirm[s]" petitioner's interpretation of Section 9(b). Pet. Br. 26, 30. The admonition is immaterial to this case, however, unless it can be shown to have meaning beyond the "in each case" language. Congress passed the "in each case" language in 1935 and has not amended it since. If petitioner is entitled to prevail under that language, the question of the effect of the admonition need not be reached. Conversely, if the 1935 statute does not prohibit the Board's regulation, the admonition is irrelevant unless it can be shown to have added a limitation on the Board's statutory authority that was not there before, that is unique to the health care industry, and that invalidates this regulation.

In its Final Rule, the Board observed that it was "inclined to agree" with the majority in *International Bhd. of Elec. Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), that the admonition did not give rise to a legal obligation. That inclination is fully justified. The admonition did not accompany an amendment of Section 9(b) and thus cannot be read to clarify the meaning of a law passed by Congress and signed by the President. But in any event, the Board regarded the admonition as an expression of the sense of Congress regarding proliferation and undertook to comply with it. The Board made clear that it was "mindful of avoiding undue proliferation, not

to make an offer of proof to preserve a claim that particular circumstances would make it unjust to apply the regulation. J.A. 190.

only because this desire was expressed in the legislative history, but also because it accords with [the Board's] own view of what is appropriate in the health care industry." J.A. 66; see J.A. 25-26.

A. In the Rulemaking, the Board Gave Due Consideration to Preventing Proliferation of Bargaining Units

In order to obtain the information it wanted on the issue of proliferation, the Board, in its first notice of proposed rulemaking, solicited answers to specific questions on the potential evils of proliferation and stressed its desire for "actual, empirical, practical evidence" on those questions. J.A. 20. With the benefit of data assembled during the rulemaking, the Board also explained why each of the units prescribed by the regulation—and the scheme as a whole—would not contribute to those evils or otherwise violate the admonition. J.A. 95-96, 110-113, 114, 120, 131, 140-144, 145-146, 158-159, 191-194, 246-254. See also J.A. 78-84 (explaining why the industry's two-units-plus-guards proposal would not be preferable to the Board's approach).

With respect to particular units, the Board cited evidence that those units would not, in practice, encourage strikes, wage whipsawing, jurisdictional disputes, or leapfrogging. For instance, the Board found that with respect to nurses, the fact that "RNs are in a different labor market mitigates against [wage] leapfrogging." J.A. 86. While acknowledging that registered-nurse units had engaged in strikes, the Board observed that nurses would generally predominate in strike votes in all-professional units, posing the risk that strikes in such units would be more serious. J.A. 110. Similarly, the Board noted, strikes involving technical workers alone were rare (J.A. 131), and the record contained no evidence that separate units of office clericals led to sympathy strikes, jurisdictional disputes, or wage leapfrogging (J.A. 158). See J.A. 141-144 (similar findings as to separate unit of skilled maintenance workers).

In the course of analyzing the industry's support for a rule prescribing three units—covering professionals, non-professionals, and guards—the Board cited statistics showing that organization of one unit in a hospital did not promote organization of other units (J.A. 79; see J.A. 193); that a large majority of all hospitals negotiated not more than three collective bargaining agreements (J.A. 79); that strikes were rare in the industry (J.A. 80-81); and that either there was no correlation between the number of units in a hospital and the frequency of strikes or the likelihood of strikes *decreased* as the number of units increased (J.A. 81-82). The Board found no evidence that multiple units contributed to jurisdictional disputes, leapfrogging, or whipsawing. J.A. 82-84. See J.A. 193-194, 251.²⁹ The Board concluded (J.A. 191):

A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

²⁹ Petitioner complains that the Board's information was defective because it was not based on experience with "a proliferation of units" (Pet. Br. 38). However, the empirical data amassed during the rulemaking—data based upon experience with proprietary hospitals, units certified by the Board, and state-certified units—provided a legitimate source of information on the proposed rule. See J.A. 252. Petitioner makes no effort to show that the evidence was insufficient to sustain the Board's conclusions under applicable legal standards. See *FCC v. National Citizens Comm. for Broadcasting*, 436 U.S. 775, 814 (1978) ("complete factual support in the record for the [agency's] judgment or prediction is neither possible nor required").

Moreover, having heard hospital bargaining-unit cases for nearly 15 years, the Board was justified in concluding that additional adjudications would not produce superior information. In those adjudicatory proceedings, the Board's information is limited by the resources and interests of the parties.

Petitioner's assertion that the Board's effort was an illegitimate attempt "to redetermine legislative facts already determined by Congress" (Pet. Br. 38) is without merit. The purpose of a delegation to an administrative agency is to assure—when Congress has been unable or unwilling to act definitively on an issue—that the agency will use its authority to gather information and employ its expertise in fashioning a response. Recognizing that Congress did not wish the question of proliferation to be resolved "in the abstract" (J.A. 253), the Board undertook "to carefully examine the exhaustive rulemaking record furnished by numerous parties from all sectors of the health care industry, and then to make a determination on appropriate units consistent with that evidence, consistent with [the Board's] self-expressed desire to avoid a proliferation of units, and consistent with a requirement that these units not be likely to produce the unwanted results of repeated work stoppages, jurisdictional disputes, wage whipsawing, and other related evils." (J.A. 253). When the Board completed that task, it had given "[d]ue consideration" to the issue of proliferation.³⁰

³⁰ Petitioner is mistaken in its assertion (Pet. Br. 35-36) that the regulation is inconsistent with the admonition's references to Board decisions. The admonition approved the holdings of two cases; petitioner misstates them both. In *Four Seasons Nursing Center*, 208 N.L.R.B. 403 (1974), the Board did not reject "a separate unit of skilled maintenance workers" (Pet. Br. 35) that would be approved under the regulation. The unit consisted of *unskilled* maintenance workers, who would be combined with service workers under the regulation (see J.A. 253 n.33); further, because the unit was in a nursing home and consisted of fewer than 5 employees, the regulation would not be applicable at all. In *Woodland Park Hosp.*, 205 N.L.R.B. 888 (1973), the only issue before the Board was whether x-ray technicians were entitled to a separate unit; the Board held, as the regulation would require, that no separate unit was appropriate. (Petitioner (Pet. Br. 36) overlooks the fact that the petitioning union did not challenge the Regional Director's decision that separate units of clericals, technicals, and other nonprofessionals were not appropriate, 205 N.L.R.B. at 888 n.3; the Board had no occasion to consider that issue.) Finally, since the admonition expressed only qualified approval of *Extendi-*

B. The Regulation Is Consistent with the "Legislative History" of the Admonition

1. On its face, the admonition does not suggest any limitation on the Board's rulemaking authority. Undaunted, petitioner reviews the legislative history of the admonition and concludes that the admonition "re-affirmed the need for case-by-case unit determinations and underscored Section 9(b)'s requirement that the Board determine the appropriate unit 'in each case'" (Pet. Br. 30). Even on the heroic assumption that the legislative history of legislative history should be given significant weight, the materials cited in support of this proposition—which consist, in their entirety, of remarks by Senators Taft and Williams on the floor of the Senate and excerpts from testimony by Undersecretary of Labor Schubert during a committee hearing—say no such thing.³¹ Those

care of West Virginia, Inc., 203 N.L.R.B. 1232 (1973), its holdings are an inappropriate benchmark against which to measure the regulation. See also note 47, *infra*.

³¹ 1974 *Leg. Hist.* 113-114 (remarks of Sen. Taft) (quoted at Pet. Br. 28-29); *id.* at 362-363 (remarks of Sen. Williams) (quoted at Pet. Br. 29 n.13); *Coverage of Nonprofit Hospitals Under National Labor Relations Act: Hearings on S. 794 and S. 2292 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 93d Cong., 1st Sess. 427, 434 (1973) [hereinafter *1973 Senate Hearings*].

It is a useful exercise to compare these materials to petitioner's inflated claims as to Congress's intent. For instance, Senator Taft's remarks did not suggest, as petitioner asserts (Pet. Br. 27), that the Taft bill "was opposed as overly rigid and unduly restrictive of the Board's flexibility to determine bargaining units on a case-by-case basis taking into account the particular situation at each hospital." Rather, he simply reported that his approach "was not adopted by the committee," referred to the admonition, and opined that the Board "should be permitted some flexibility in unit determination cases." (The relevant passage is quoted at Pet. Br. 28-29.) There is no support whatever for petitioner's assertion that the admonition was intended to deny the Board the option of addressing proliferation through rulemaking—i.e., to "requir[e] that the Board, in carrying out its required case-by-case determinations"

statements include no discussion whatever of the relative merits of rulemaking and adjudication or the limits on either, no mention of Section 9(b), and only the vaguest indications as to how the speakers expected the Board to proceed. Even at the level of generalities, the protagonists in the committee that drafted the admonition, Chairman Williams and Senator Taft, presented divergent explanations of its meaning.³²

2. The Board's view of the significance of the admonition is fully justified. In 1972, the House passed a bill, H.R. 11357, 92d Cong., 2d Sess., that would simply have deleted the NLRA exemption for nonprofit hospitals. See 118 Cong. Rec. 27,128-27,136 (1972). In the Senate, the hospital industry, led by petitioner, sought to preserve the exemption. In hearings before a Senate committee, a representative of petitioner testified that the Act was "inappropriate for application[] to the health care field" for two reasons: "The first involves strikes, picketing, and impasses. The second pertains to the fragmentation and proliferation of bargaining units."³³ Alluding to decisions involving proprietary hospitals in which the Board had permitted separate units for some discrete professional and nonprofessional groups,³⁴ AHA asserted that "[a]dditional bargaining units can be pro-

(Pet. Br. 28), to consider proliferation only in each individual adjudication.

³² Compare 1974 *Leg. Hist.* 113-114 (remarks of Sen. Taft) with *id.* at 362-363 (remarks of Sen. Williams). See also *id.* at 361-362 (remarks of Senator Williams).

³³ *Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1972: Hearings on H.R. 11357 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 92d Cong., 2d Sess. 33 (1972) (testimony of David Hitt) [hereinafter 1972 Senate Hearings].*

³⁴ See, e.g., *Syosset General Hospital*, 190 N.L.R.B. 304 (1971) (pharmacists); *Ochsner Clinic*, 196 N.L.R.B. 10 (1972) (radiologic technologists); *Birnbaum*, 178 N.L.R.B. 478 (1969) (licensed practical nurses).

jected for many other professional and paraprofessional groups as well as for the many crafts which are vital to the functioning of health care institutions such as engineers, carpenters, plumbers, electricians, and maintenance workers." 1972 *Senate Hearings* 35. Other witnesses from the hospital industry echoed petitioner's warning of the possibility of highly fragmented bargaining units along craft lines.³⁵ No bill was reported to the Senate floor.

The following year, when the industry proved unable to defeat repeal of the exemption altogether, petitioner supported legislation that would, *inter alia*, prescribe five bargaining units in health care facilities. See 1973 *Senate Hearings* 147-148. That proposal was incorporated in a bill introduced by Senator Taft. S. 2292, 93d Cong., 1st Sess. (1973) (*reprinted in 1974 Leg. Hist.* 449, 457-458). The Taft bill encountered opposition and was abandoned in favor of a compromise bill. The compromise bill contained some provisions addressing strikes and picketing, but simply extended Section 9(b) to the health care industry; as part of the compromise, the admonition was included in the committee reports.³⁶ See pp. 3-4, *supra*.

³⁵ See 1972 *Senate Hearings* 158, 238-239, 300-301. The industry's concern with highly fragmented units was reiterated during hearings the following year. 1973 *Senate Hearings* 128-129, 139-140, 160-161, 175, 181, 198-200, 273-274, 443, 465-466. But Congress received no testimony manifesting specific concern as to the units prescribed by the Board's regulation. Thus, when Senator Taft referred to the admonition on the Senate floor, he joined with the industry in decrying the results of permitting "each professional interest and job classification * * * to form a separate bargaining unit" and in arguing that health-care institutions "must not be permitted to go the way of other industries, particularly the construction trades, in this regard." 1974 *Leg. Hist.* 113, 114.

³⁶ Industry representatives generally supported the Taft approach to bargaining unit determination, see 1973 *Senate Hearings* 129, 181, 188; union representatives opposed it, see *id.* at 49, 59-60; and the Labor Department considered the provision unnecessary, *id.* at 434.

This history strongly supports the Board's understanding of the significance of the admonition—that "Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately" (J.A. 191) and that the Board was to exercise informed discretion in resolving the issue (J.A. 253). The Board has never suggested that "Congress would be satisfied with any number [of units] less than 15" (Pet. Br. 35); to the contrary, recognizing that the admonition reflected concern with avoiding strikes, jurisdictional disputes, and wage whipsawing, the Board undertook a detailed study of whether the units it had selected would engender those evils and concluded they would not.³⁷ Petitioner tried and failed to achieve passage of a bill that would have provided for five units in every health care facility; its opposition to the Board's present regulation, which permits a maximum of eight units in acute care hospitals, is an attempt to win in this Court what it was unable to obtain in Congress.³⁸

³⁷ As petitioner notes, various courts of appeals held that Board decisions in bargaining unit determinations were inconsistent with the admonition. See notes 3-4, *supra*. However, for the most part, those decisions faulted the Board for failing adequately to consider whether its decision was consistent with the admonition. The regulation is not subject to that criticism; for that reason, the Seventh Circuit did not regard its decision in *Mary Thompson Hosp. Inc. v. NLRB*, 621 F.2d 858 (1970), to foreclose the regulation.

³⁸ Petitioner's assertion (Pet. Br. n.18) that the admonition was a compromise between "those who favored repeal of the hospital exemption and those who opposed repeal" ignores Senator Taft's acknowledgment, when he introduced his 5-unit proposal, that the question whether the Act should be extended to nonprofit hospitals was no longer in issue. 1973 Senate Hearings 75.

III. THE REGULATION IS NOT ARBITRARY, CAPRICIOUS, OR AN ABUSE OF DISCRETION

In determining whether agency action is arbitrary or capricious, "the reviewing court 'must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' This inquiry must 'be searching and careful,' but 'the ultimate standard of review is a narrow one.'" *Marsh v. Oregon Natural Resources Council*, 109 S. Ct. 1851, 1861 (1989). Accord *Bowman Transportation, Inc. v. Arkansas-Best Freight Systems, Inc.*, 419 U.S. 281, 285 (1974); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971). Moreover, where an agency is analyzing facts or making predictions within its area of expertise, review is at its most deferential. See *Marsh v. Oregon Natural Resources Council*, 109 S. Ct. 1860-1861; *Baltimore Gas & Electric Co. v. Natural Resources Defense Council, Inc.*, 462 U.S. 87, 103 (1983); *FCC v. National Citizens Comm. for Broadcasting*, 436 U.S. at 813-814. See also *Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 43 (1983). Judged under these standards, the Board's regulation should be upheld. Indeed, the Board's painstaking evaluation and analysis of the data submitted, and its detailed explanation of the basis of its action, would withstand challenge under a far more rigorous standard of review.

Petitioner contends that the Board's regulation is arbitrary and capricious in "ignor[ing] critical differences among the more than 4,000 acute care hospitals in the United States, including differences in size, location, operations, and workforce organization." Pet. Br. 39.³⁹

³⁹ Petitioner also argues (Pet. Br. 38, 40) that the regulation is unsupported by substantial evidence within the meaning of 5 U.S.C. 706(2)(E). However, the substantial evidence standard applies only to "a case subject to sections 556 and 557 of [Title 5] or otherwise reviewed on the record of an agency hearing provided by statute," *ibid.*, and not to "regulations promulgated after informal

This is simply not so. The regulation does not ignore variations in the health care industry that are material to bargaining unit determinations. Rather, the Board acknowledged those variations among health care facilities that warranted modification of the regulation. Thus, the regulation was amended to exclude certain categories of facilities that the Board's original proposal would have covered—nursing homes, psychiatric hospitals, rehabilitation hospitals, and drug treatment facilities. With respect to the remaining category (acute care hospitals), the Board distinguished between those variations that may be material to the selection and definition of an appropriate unit—which will be litigated under the “extraordinary circumstances” exception and in other specific contexts (see J.A. 123 n.23, 149, 160, 216 n.2, 225-226)—and variations that the rulemaking and the Board's experience demonstrated are not material. The Board's “considered judgment . . . that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units” (J.A. 188-189) is fully supported by its experience and by the administrative record.

A. The Regulation Is Not Arbitrary or Capricious By Virtue of Inconsistency with Other Board Actions

Petitioner's principal contention (Pet. Br. 40-41, 43-45 & nn. 27-29) is that the regulation represents an unexplained and unjustified departure from the Board's observation in a footnote in *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39 (1984) (*St. Francis II*), remanded *sub nom. International Bhd. of Elec. Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), and from subsequent decisions by the Board's Regional Directors. Even taken at face value, that argument does not provide a sufficient basis for invalidating the regulation. A rule that is otherwise justified by an agency's experience and

rulemaking,” *FCC v. National Citizens Comm. for Broadcasting*, 436 U.S. at 802-803.

a voluminous rulemaking record is not arbitrary and capricious because it contradicts a footnote in an agency decision or rulings by subordinate agency officials. What is more, petitioner's contention is untenable even on its own terms. Petitioner asserts inconsistencies that do not exist, and fails to acknowledge the Board's full explanation of the approach embodied in the regulation.

1. Although petitioner's partial quotation (Pet. Br. 40) is calculated to obscure the point, *St. Francis II* did not say that generalizations regarding appropriate bargaining units in acute care hospitals were never possible. The Board said in *St. Francis* (271 N.L.R.B. at 953 n.39 (emphasis added)):

The diverse nature of today's health care industry—including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc.—precludes any generalization as to the appropriateness of any particular bargaining unit. However, despite these diversities, the disparity-of-interests test can and will be applied to all these facilities. *We anticipate that after records have been developed and a number of cases decided from these records, certain recurring factual patterns will emerge and illustrate which units are typically appropriate.*

This observation is consistent with the Board's regulation. First, the diversity to which the Board referred was principally among different types of health care facilities. The Board's regulation does not apply to many of those facilities, such as nursing homes, blood banks, and outpatient clinics. Second, the Board foresaw that “recurring factual patterns” among care facilities would permit identification of “typically appropriate” units. The rulemaking served to identify those areas in which generalizations regarding bargaining units were possible and, on that basis, specified appropriate bargaining units.

2. *St. Francis II* was a significant decision, but not in the sense petitioner suggests. Before that decision, the Board had employed its traditional “community of in-

terest" approach to determine appropriate bargaining units in health care facilities. See pp. 4-5, *supra*. In *St. Francis II*, however, the Board reexamined a prior decision in which it had found a separate maintenance unit appropriate and adopted the disparity of interests test advocated by the Ninth and Tenth Circuits.⁴⁰ Applying that test, the Board reversed its earlier finding that a separate maintenance unit was appropriate.

Although *St. Francis II* was vacated by the D.C. Circuit on the ground that the Board had accorded too much significance to the admonition, upon remand the Board reasserted its adherence to the disparity of interests test, this time in the exercise of its discretion, and reaffirmed its holding that a separate maintenance unit was not appropriate. *St. Francis Hosp.*, 286 N.L.R.B. 1305 (1987); see *St. Vincent Hosp. & Health Center*, 285 N.L.R.B. 365 (1987) (holding that a separate unit of registered nurses was not appropriate). Thereafter, while the rulemaking was underway, the Board continued to apply that standard. J.A. 180-183. Thus, when regional directors were called upon to determine the appropriateness of separate units of nurses, maintenance workers, and other categories of employees after *St. Francis II*, they rendered decisions consistent with the holdings of that case and *St. Vincent*. Petitioner cites some of those cases. Pet. Br. 44 nn. 27-28.⁴¹

The Board acknowledged that there was inconsistency in its decisions regarding certain of the units prescribed in the regulation, but explained why the regulation was nonetheless appropriate. See J.A. 5-8, 55-56, 64, 115-116

⁴⁰ See note 4, *supra*; J.A. 63. *St. Francis II* reversed the Board's decision in *St. Francis Hosp.*, 265 N.L.R.B. 1025 (1982).

⁴¹ In two of the Regional Directors' decisions, *Wilmington Medical Center*, No. 4-RC-14780 (NLRB Reg. 4, Apr. 19, 1985) and *St. Joseph Hosp.*, 4-RC-14543 (NLRB Reg. 4, Dec. 24, 1984) (Pet. Br. 44 n.28), the Regional Director initially found separate maintenance units appropriate and reversed those decisions after remand from the Board based on *St. Francis II*.

& n.22, 146-147. First, on the basis of an analysis of the results of its cases, it found that doctrinal formulations—and not the facts of individual cases—had given rise to the divergence in its decisions (J.A. 55):

Our adjudicatory decisions as to appropriate units in the health care industry, where the facts of each case were painstakingly examined in numerous lengthy and costly representation proceedings, have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests.⁴²

Accordingly, the Board concluded that it would be "unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach," to continue to scrutinize the facts of each individual case. J.A. 56. Instead, the Board undertook an exhaustive empirical study of the factors deemed relevant under both the community of interest and disparity of interests tests in fashioning appropriate units in the rulemaking (J.A. 67-68).⁴³

Second, the Board noted that the information obtained during the rulemaking had cast doubt on the Board's disparity of interests decisions. With respect to nurses, the Board observed that, in the aftermath of *St. Francis II*, "RNs consistently desired separate RN units but were compelled to organize into all-professional units in order

⁴² The Board found that from 1975 through 1984, the period during which the Board applied the community of interest test to the facts of each case, the Board "found RN units appropriate in 24 of 25 published cases [the one exception involving a psychiatric hospital outside the scope of the Board's rule]; technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc." J.A. 56.

⁴³ Those factors included, among others (J.A. 67-68):

uniqueness of function; training; education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective bargaining, such as bargaining history, matters of special concern, etc.

to avoid prolonged litigation"; the organizing drives directed to all-professional units "were quite similar to prior nurses-only campaigns"; and "non-nursing professionals did not wish to be included in a unit with RNs," threatening the cohesiveness of the unit. J.A. 115-116. The Board noted that "were [it] to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*." J.A. 115 n.22. The Board also took care to explain the divergence between the regulation and certain decisions addressing other units. J.A. 146-147 (skilled maintenance unit); J.A. 159-160 (office clerical unit). As the Board noted, the units prescribed by the rule were consistent with virtually all of its decisions prior to its adoption of the disparity of interests test.⁴⁴

There was no deficiency in the Board's explanation of how the regulation related to conflicting lines of authority in its prior adjudications. To the contrary, the Board acknowledged the divergence in its prior decisions, located the source, and fashioned an entirely reasonable response consistent with many of those decisions.⁴⁵

⁴⁴ The validity of the regulation is not undermined by the fact that it yields bargaining units that are frequently requested by unions and that have often been adopted by the Board. It is to be expected that the units found to guarantee effective representation for employees will correspond to the homogenous groups that have sought to organize themselves; that result affords employees a genuine opportunity to bargain—an opportunity Congress found would improve the delivery of health care in the United States. *Beth Israel Hosp. v. NLRB*, 437 U.S. at 499-500.

Ironically, petitioner suggests that the regulation is arbitrary and capricious *both* because it is inconsistent with the results of some of the Board's post-1984 cases (Pet. Br. 40-42) and because it is consistent with virtually all of the pre-1984 cases (*id.* at 46-47).

⁴⁵ In *Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. at 42, this Court noted that when an agency alters its policies, it is "obligated to supply a reasoned analysis for the change beyond that which may be required when an agency does not act in the first instance." The Board provided just such an analysis in the explanatory statements it issued in

3. Finally, the results of many of the cases on which petitioner relies are not inconsistent with the regulation. For instance, *Jewish Hosp. & Rehabilitation Center*, No. 22-RC-9442 (NLRB Reg. 22, Aug. 27, 1985) (Pet. Br. 44 n.27), involved a rehabilitation center and nursing home that is beyond the scope of the regulation. J.A. 261; see J.A. 165-176, 236-240. In three other decisions cited by petitioner, the unions sought broad wall-to-wall or all non-professional units.⁴⁶ Under the regulation, a union has the

the course of the rulemaking. The Board has "responsibility to adapt the [NLRA] to changing patterns of industrial life," taking account of "its cumulative experience in dealing with labor-management relations." *NLRB v. Weingarten, Inc.*, 420 U.S. 251, 266 (1975); see also *NLRB v. Seven-Up Bottling Co.*, 344 U.S. 344, 349 (1953).

⁴⁶ *Titusville Hosp.*, No. 6-RC-973 (NLRB Reg. 6, July 30, 1986), slip op. 2-3 (see Pet. Br. 44 n.27) (employer sought, and union opposed, decertification of professionals from wall-to-wall unit certified by state board prior to 1974); *Twin City Hosp. Corp.*, Nos. 8-RC-13686 & 8-RC-13687 (NLRB Reg. 8, Nov. 10, 1987), slip op. 2 (see Pet. Br. 44 n.27) (union sought and employer did not oppose broad nonprofessional unit); *Santa Rosa Hosp.*, No. 20-RC-15845 (NLRB Reg. 20, June 7, 1985) (Pet. Br. 45 n.29) (union sought unit of all nonprofessional employees). Further, the cited passage in *Twin City Hosp. Corp.*, slip op. 6, focused on the *unit placement* question whether medical technologists should be classified as professional or non-professional employees; the regulation specifically reserves that issue for resolution in individual adjudications. J.A. 131-132, 243-244.

Finally, *Santa Rosa Hosp.* is a striking illustration of the Board's observation (J.A. 52-53) that litigation of factual issues in unit determinations often serves only to delay the holding of an election. In *Santa Rosa*, the union sought a broad non-professional unit, in keeping with petitioner's position here. Nevertheless, the employer argued "that there are disparities of interest among the various categories of employees sought by the petition, without stating a position as to which, if any, of the disparities are of critical significance." Slip op. 2. As a result, the regional director was compelled to examine "the specifics of the various categories * * * which may or may not be disputed." *Ibid.*

option of seeking to represent "various combinations of units." J.A. 260; see J.A. 185-186.

B. The Board's Conclusion that, Absent Extraordinary Circumstances, Differences Among Acute Care Hospitals Are Not Material to the Appropriateness of Bargaining Units Was Carefully Explained and Fully Justified

Petitioner also asserts (Pet. Br. 42) that the Board "offered no reason why evidence of differences among hospitals did not undercut its finding that 'there are such similarities that certain institutions may properly be grouped as a class'" and that the Board "blithely disregarded hundreds of letters submitted by hospitals detailing their size and workforce structure and the effect that the rule would have on their institutions." The record establishes otherwise.

1. The Board specifically addressed the industry's claim that variations among hospitals and developments in the health care industry precluded adoption of a regulation prescribing bargaining units in the absence of extraordinary circumstances. J.A. 49-60. It conscientiously summarized comments on both sides of that issue (J.A. 49-51, 52-55) and explained why it believed a regulation to be appropriate. That explanation took two forms. First, focusing on the variations themselves, the Board noted that diversity among hospitals had not theretofore affected the results of bargaining unit adjudications and that neither financial constraints nor diversification of institutions occurring within the industry made rulemaking any less appropriate. J.A. 55-59.

Second, in justifying the individual bargaining units prescribed by the regulation, the Board cited factors supporting generalizations as to the appropriateness of those units. For instance, with respect to nurses, the Board found that, despite various systems of organization, the director of nurses invariably has supervision of RNs (J.A. 93-94); that RN licensing exams are uniform

throughout the country (J.A. 97); and that "licensing and other regulations" preclude interchange of work and cross-training between RNs and other professionals (J.A. 98, 101). The Board's discussion of each of the prescribed units discloses the generalizations on which the unit was based and the experience or record evidence underlying those generalizations. See J.A. 91-161, 224-229.

Petitioner fails to come to terms with the Board's explanation. For instance, it characterizes the Board's supposed failure to explain why technical employees and skilled maintenance employees were not included in a single unit as "[p]erhaps the most telling example" (Pet. Br. 45) of the regulation's shortcomings. The Board's detailed explanation of why these categories of employees should be separated from the service and maintenance unit prescribed by the regulation, however, leaves no doubt why those categories differ from one another. See J.A. 122-161. For example, the Board noted that the wages and hours of technical employees differ significantly from those of other non-professionals; that there is a sizeable and widening gap between the level of skills required of technicals and that required of other non-professionals; that there is no temporary interchange and little permanent interchange between the two groups; and that technical employees have separate career paths and labor markets. J.A. 123-129.⁴⁷

2. Petitioner's so-called "representative sample" of comments from hospitals (Pet. Br. 42 n.24) does not undermine the Board's conclusions. Far from "detailing [the hospitals'] size and workforce structure" (*id.* at

⁴⁷ In *Extendicare of West Virginia, Inc.*, 203 N.L.R.B. 1232 (1973), the union requested three separate units: licensed practical nurses, technical employees, and all other service and maintenance personnel. The Board's decision permitted two units: LPNs and all other service and maintenance personnel. Given a similar union request, the regulation would also provide for two units: technical employees and all other service and maintenance personnel (including LPNs).

42), the cited letters were, in the main, one- or two-page statements of opposition to the regulation unaccompanied by the "actual, empirical, practical evidence" (J.A. 20) that the Board requested. Moreover, the regulation actually accommodates many of the concerns addressed in the letters petitioner cites—presumably, the most favorable to its position that an undoubtedly diligent search of the voluminous record managed to turn up.⁴⁸

⁴⁸ Citing the one-page comment of Marshalltown Medical & Surgical Center (Ct. App. Supp. App. 370), petitioner asserts that hospitals have utilized cross-training that cuts across the units determined in the regulation. The one example given by Marshalltown was security guards who work the switchboard and do maintenance work; security guards, by statute (see 29 U.S.C. 159(b)(3)), cannot be included in more comprehensive units. See J.A. 225 (addressing this comment). The comment of Michael Reese Hospital (Ct. App. Supp. App. 375-377) detailed its experience with three separate units—which the hospital had voluntarily recognized—of electricians, operating engineers, and firemen and oilers. The regulation would require all those employees to be included in one skilled maintenance unit. This comment also noted that skilled maintenance personnel move throughout the hospital performing their jobs (see Pet. Br. 44); the Board explained (J.A. 136) why that situation did not render inappropriate a separate skilled maintenance unit. The complaints in this comment about seniority and mobility were attributable to the particular terms of the collective agreements the hospital agreed to; they were not mandated by the unit structure.

The remaining comments cited by petitioner deal with the costs associated with collective bargaining. The Board noted that the Robfogel testimony (Ct. App. Supp. App. 384-411) "relating to the costs for negotiations at a public hospital in Massachusetts with eight bargaining units (* * * where out-of-state as well as local attorneys appeared for each negotiating session) was not shown to be typical." J.A. 85. Moreover, the Board correctly noted that "it would not be suitable for the Board to reject appropriate bargaining units on the basis that the very things sought by collective bargaining—negotiating and grievance processing—can be obtained only at some financial cost. The statutory amendments enacted by Congress in 1974 represented an implicit policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the costs." J.A. 220.

A number of petitioner's *amici* seek to buttress petitioner's arbitrary and capricious challenge by arguing the impact of the regula-

More fundamentally, pointing to a few submissions whose assertions may be at odds with an agency determination does not establish that the agency acted arbitrarily or capriciously. The Board's experience, supplemented by the rulemaking record, provided a more than sufficient basis for its conclusions.

* * * * *

Petitioner's claim that the regulation is "arbitrary and capricious" is, in essence, an ineffective effort to pick a few holes in a regulation that represents the fruit of some two years of exhaustive inquiry, analysis, and review. And the firm foundation on which the regulation rests also underscores the weakness of petitioner's effort to overturn it as somehow not in accordance with law. The regulation does not violate the agency's statutory mandate; it fulfills it.

tion on particular hospitals. Of course, these arguments are irrelevant to the extent they are unsupported by references to the administrative record.

CONCLUSION

The judgment of the court of appeals should be affirmed.
Respectfully submitted.

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APPENDIX

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**BRIEF FOR THE RESPONDENTS
AMERICAN NURSES ASSOCIATION, AMERICAN
FEDERATION OF LABOR AND CONGRESS OF
INDUSTRIAL ORGANIZATIONS, AND THE
BUILDING AND CONSTRUCTION TRADES
DEPARTMENT, AFL-CIO**

This brief is submitted jointly on behalf of the three union respondents in this case: the American Nurses Association, the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO"), and the Building and Construction Trades Department of the AFL-CIO. The union respondents accept the statement of the opinions below, the statement of jurisdiction, and the statement of the statutory provisions involved contained in the brief of petitioner American Hospital Association. And to avoid duplicative submissions, the union respondents leave it to the respondent National Labor Relations Board, whose position in this matter we fully support, to state the case for the Court.

SUMMARY OF ARGUMENT

I. The brief of the National Labor Relations Board ("NLRB" or "the Board") demonstrates that petitioner American Hospital Association ("AHA") misunderstands § 9(b) of the National Labor Relations Act, as amended, insofar as the AHA contends that the section commands the Board to base its unit decision on "individual case-by-case evaluation." We show that the AHA equally misunderstands the nature of the decisions the Board is called upon to make under § 9, and that the AHA's "case by case" approach would lead to a regime which would defeat the policies of the Act. Pp. 3-21 *infra*.

Under § 9 the NLRB decides whether a proposed grouping of employees is an appropriate predicate for collective bargaining. Such determinations can logically be made across an industry based upon considerations that do not vary from case to case; for example, jobs

can be grouped into units based upon the functions the jobs entail and the training and skills required to perform the jobs. That is precisely what the Board did here.

Furthermore, the policies of the Act demand that unit determinations be made across an industry. The electoral system the NLRA creates could not work if the boundaries of the election unit had to be decided anew in each case based on employer-specific considerations. And, the ability of employees to eliminate wage competition through collective bargaining would be effectively nullified if, within a given labor market, unit configurations varied from employer to employer.

II. The admonition regarding unit "proliferation" contained in the committee reports accompanying the 1974 Health Care Amendments does not provide an independent basis for overturning the Rule. Congress made a deliberate decision in 1974 not to legislate with respect to hospital unit determinations; the fair inference, therefore, is that Congress did not intend to disturb the Board's preexisting discretionary authority in this regard. Moreover, regardless of what the 1974 Congress may have thought regarding unit determinations, its views are entitled to no weight in determining the Board's legal obligations because that Congress failed to translate its sentiments into positive law. The views expressed in the admonition do not illuminate the statutory text but at most state a consideration which a subsequent Congress wished—but did not mandate—the Board to "consider" in a category of cases. Pp. 21-36 *infra*.

III. The Board did not act arbitrarily or capriciously in promulgating a rule that applies to acute care hospitals generally. The rulemaking record establishes that such hospitals share many characteristics in common; most importantly, in such hospitals there are discrete functions which require discrete sets of skills and training and which are performed by discrete groups of

employees. These considerations do not vary based on the size, location, or particular mix of services provided by a hospital. Indeed, when all is said and done, the AHA fails to offer even a single instance in which the findings underlying the Rule do not apply, let alone any cogent demonstration that the Rule's generalizations are so off-target as to be arbitrary and capricious. Pp. 37-50 *infra*.

ARGUMENT

Introduction

This case is about appropriate bargaining units in acute care hospitals, and about the authority of the National Labor Relations Board ("NLRB" or "the Board") to define such units by general rule. But to state the issues in these terms obscures as much as it reveals.

As Professor Gorman has observed, the term "bargaining unit" is something of a misnomer. Because "employees represented in different . . . units may choose to 're-group' as a single larger entity for purposes of conducting actual negotiations," the "composition of the *negotiating* unit will . . . frequently depend less upon the Board's unit determination than upon the structure of the employer and the union and upon alliances among employees or unions." R. Gorman, *Basic Text on Labor Law* 66 (1976) (emphasis in the original).¹

The real significance of the NLRB's "bargaining unit" determinations is, as Professor Gorman states, to define the "*election* unit" within which representation elections take place. *Id.* (emphasis in the original). Herein lies the heart of this case, for inevitably unit determinations profoundly influence election outcomes. As Judge Posner explained in his opinion below:

This is because the smaller and more homogenous a bargaining unit is, the easier it will be for the mem-

¹ See also J.A. 89-90 (describing experience in New York hospitals).

bers to agree on a mutually advantageous course of collective action, and therefore the more attractive a union will be . . . By the same token, the larger and more heterogeneous the unit is the harder it will be for the members to agree on a common course of action. [Pet. App. 3a²]

In promulgating the Rule which is at issue here, the NLRB—after finding that grouping all professional or all non-professional hospital employees in a single unit “would result in too diversified a constituency,” J.A. 61; *see id.* at 88-91—set about to identify a “reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities,” J.A. 67.

The rulemaking record persuaded the Board that among professional hospital employees two groups—physicians and registered nurses—possess “truly distinctive interests and concerns,” J.A. 191, which justify allowing each of these groups to organize on a separate basis, (although, as the Board noted, many hospital physicians are “independent contractors” and are precluded from organizing for that reason, *see* J.A. 251). Among nonprofessional hospital employees the Board found three such “natural groupings”—medical technicians, business office clericals, and skilled maintenance craft employees.

The record further persuaded the Board that these groups—plus a residual all-other professional group, a

² Robert Muehlenkamp, Executive Vice President of the National Union of Hospital and Health Care Employees, put it this way in his testimony before the Board in the rulemaking proceeding:

What I think we are talking about is whether or not there will be voting groups such that those . . . who see that they have more separating them than they have in common will be put together into voting groups so that those who do want to participate in collective bargaining are deprived of the right, and those that did not want to be involved in the process at all . . . destroy the opportunity for those who . . . wanted to engage in collective bargaining. [Tr. 4759]

residual all-other nonprofessional group and a guards group as required by the Act³—will

not be so large that organizing them is exceedingly difficult and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. [J.A. 67⁴]

Accordingly, the Board adopted the Rule which provides that absent “extraordinary circumstances,” employees in any one of the five groups identified by the Board (or in one of the residual groups) may elect to organize as a separate unit, but that no other subgroup of professionals or non-professionals may do so.

Significantly, the brief of petitioner American Hospital Association (“AHA”), does *not* challenge either the Board’s finding that each of these units represents a “natural grouping” with “truly distinctive and concerns” or the Board’s finding that these units are sufficiently broad and functionally distinct as not to beget whipsawing or labor unrest. Instead, in a variety of timbres and in a

³ Section 9(b)(3) of the National Labor Relations Act, as amended, 29 U.S.C. § 159(b)(3), mandates a separate unit for guards which unit cannot be represented by any union that represents any non-guards employed by any employer in any industry. In practice, such units are “rarely sought.” J.A. 193.

⁴ In reaching this latter conclusion, the Board drew upon a wealth of empirical evidence presented in the rulemaking concerning the actual bargaining experience in the various units proposed by the Board. That evidence included studies of the thousands of hospital collective bargaining agreements negotiated since the 1940’s by the Service Employees International Union, the National Union of Hospital and Health Care Employees, and the International Union of Operating Engineers and a study of all the hospital collective agreements—some 7,431—which, according to Federal Mediation and Conciliation Service records, were negotiated in any organized hospital during the three years preceding the rulemaking hearings. *See* WS Gerry Shea, pp. 1-2; IUOE Ex. 2 (revised); AFL-CIO Exs. 5-6.

number of keys, the AHA sounds but a single note: the NLRB is without the legal authority to identify groupings of employees which ordinarily will constitute appropriate units in an acute care general hospital.

According to the AHA, § 9(b) of the National Labor Relations Act, as amended, 29 U.S.C. § 159(b) ("NLRA" or "the Act"), prohibits this approach and demands "individual, case-by-case bargaining unit determinations." AHA Br. at 16; *see id.* at 13-25. So, too, does the Health Care Amendment Act of 1974, P.L. 93-360 ("the 1974 Amendments"). *See* AHA Br. at 26-38. And in any event, says the AHA, "it was folly for the Board even to try to develop a rule that would designate specific bargaining units . . . because the great diversity in the industry makes such an approach inherently arbitrary and capricious." AHA Br. at 40.

In the sections that follow, we treat with each of these contentions in turn. Before doing so, however, one preliminary observation is in order.

If either NLRA § 9(b) or the 1974 Amendments have the effect of prohibiting the Board from "particularizing statutory standards through the rulemaking process," *FPC v. Texaco*, 377 U.S. 33, 39 (1964), these are singular—and suspect—statutes indeed. The rule of law is, as Justice Scalia has argued in his Holmes lecture, a "law of rules," Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175 (1989), and not an institutionalization of the "kadi under a tree dispensing justice according to considerations of individual expediency," *Terminiello v. Chicago*, 337 U.S. 1, 11 (1949) (Frankfurter, J., dissenting). Thus, as Holmes himself told us, "the tendency of the law must always be to narrow the field of uncertainty." O. W. Holmes Jr., *The Common Law* 127 (1881).

Administrative agencies provide a working mechanism for reaching that goal. The genius of our administrative law system, as the late Judge Friendly observed, is that it enables an expert body to take a general statutory standard—such as § 9(b)'s requirement that each bar-

gaining unit be "an appropriate unit"—and to "define and clarify it—to canalize the broad stream into a number of narrower ones . . . to the point of affording a fair degree of predictability of decision in the great majority of cases." Friendly, *The Federal Administrative Agencies: The Need for Better Definition of Standards*, 75 HARV L. REV. 863, 874 (1962). Administrative-agencies, no less than courts, are thus charged with the task of "isolating facts pertinent to all the cases which may form the basis for a rule." *Id.* at 877.

For many years—indeed until this very case—the AHA saw the Labor Board's task in defining appropriate bargaining units in these classic terms. Thus, when the Board, after acquiring jurisdiction over non-profit hospitals in 1974, extended comity to unit determinations which had been made by state administrative agencies prior to the 1974 Amendments, the AHA complained to the courts of appeals that the Agency was frustrating "Board development of a *uniform national approach* to appropriate units in the . . . health care industry."⁵

Moreover, when the NLRB began making its own hospital unit determinations and vacillated in its treatment of the skilled maintenance employees, the AHA protested that

The absence of uniformity in these decisions serves to generate confusion as to where maintenance employees belong or will be placed in future cases. *One of the functions of case law, including administrative case law, is the predictability and precedent that it secures. The Board's maintenance unit decisions do not serve this important goal.*⁶

⁵ Brief for the AHA as Amicus Curiae in *Memorial Hospital of Roxborough v. NLRB*, C.A. No. 75-2198 (3rd Cir. 1976), p. 14 (emphasis added); Brief for the AHA as Amicus Curiae in *Long Island College Hospital v. NLRB*, C.A. No. 77-4038 (2nd Cir. 1977), p. 16 (emphasis added).

⁶ Brief for the AHA as Amicus Curiae in *St. Vincent's Hospital v. NLRB*, C.A. No. 77-1027 (3rd Cir. 1977), pp. 4-5 (emphasis added); Brief for the AHA as Amicus Curiae in *NLRB v. West*

And in the lead hospital bargaining unit prior to the promulgation of the Rule, the AHA urged the Board to declare an all-professional unit and an all non-professional unit to be the "primary bargaining units" for all hospitals and to require "*extraordinary and compelling circumstances*" to justify variations from these units.⁷

It is not difficult to understand why the AHA no longer sees virtue in "uniform[ity]" and "predictability," and now disdains a hospital bargaining unit rule which designates "primary units" and applies in all but "extraordinary" cases (as the AHA once urged). For the rulemaking record makes quite clear that the "individual case-by-case" approach the AHA now champions has substantially prolonged the process of making unit determinations and to that extent has served well the interests of the hospitals which desire to frustrate employee organization.⁸ In contrast, the Rule the NLRB has promulgated is designed to further Congress' intent in enacting the 1974 Amendments which was, as this Court has observed, to "overcome the poor working conditions retarding the delivery of quality health care" through "extension of organizational and collective-bargaining rights" to health care employees. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 498, 500 (1978).

As we proceed to show—and as the AHA itself once recognized—nothing in the NLRA, the 1974 Amendments, or the nature of the hospital industry precludes the Board from "canaliz[ing] the broad stream" of § 9 into "narrower ones" by identifying groupings of em-

⁷ *Suburban Hospital*, C.A. No. 77-1340 (7th Cir. 1978), pp. 2-3 (emphasis added).

⁸ Brief Amicus Curiae on Behalf of the American Hospital Association in *St. Francis Hospital, Inc.*, NLRB Case No. 26-CA-10060, pp. 19-20 (emphasis added).

⁹ See WS Profs. Delaney & Sockell, p. 23. See also Note, *The National Labor Relations Board's Proposed Rule on Health Care Bargaining Units*, 76 U. VA. L. REV. 115, 151-52 (1990).

ployees which, absent extraordinary circumstances, constitute appropriate hospital bargaining units.

I. THE NLRB CORRECTLY, AND IN ALL EVENTS RATIONALLY, INTERPRETED NLRA SECTION 9(b) TO PERMIT THE BOARD TO BASE ITS UNIT DECISIONS ON RULES OF GENERAL APPLICABILITY.

In its initial Notice of Proposed Rulemaking, J.A. 15-19, in the second Notice of Proposed Rulemaking, J.A. 46-47, and in the Preamble to the Final Rule, J.A. 211-17, the NLRB carefully considered its authority to delimit bargaining units by general rule and concluded that, as Professor Kenneth Davis has argued (along with many other commentators):

The mandate to decide "in each case" does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to. [K. Davis, *Administrative Law Text* 145 (3rd ed. 1972), quoted in J.A. 16, 47]

Ignoring completely the deference owed to the NLRB's interpretation of the Act it administers, *e.g.*, *NLRB v. Food & Commercial Workers*, 484 U.S. 112, 123 (1988), the AHA argues that the Board misconstrued § 9(b). According to the AHA's present position, the command to the Board to render unit decisions "in each case" is a command that the Agency base its unit decisions on "individual case-by-case evaluation," AHA Br. at 19, "taking into account the circumstances of the particular hospital," AHA Br. at 47. Indeed, according to the AHA, determining whether a bargaining unit is appropriate is analogous to assessing the "individual abilities" of a claimant for disabilities benefits in that, in the AHA's view, both types of determinations "involve[] . . . matters of historic fact, unique to each [case]." AHA Br. at 22.

Thus, according to the AHA, while the Board may “adopt rules establishing general principles to guide the required case-by-case bargaining unit determinations” such as rules “stating the factors regional directors should weigh,” the NLRB is precluded from formulating rules of decision which are inconsistent with “[s]ection 9(b)’s requirement of meaningful, case-by-case bargaining unit determination.” AHA Br. at 19, 20.

It is important to be clear as to the full sweep of the AHA’s argument. Most obviously, the AHA reads § 9(b) as a “specific exception” to, AHA Br. at 25—and limitation upon—the Board’s authority under NLRA § 6, 29 U.S.C. § 156, “to make . . . such rules and regulations as may be necessary to carry out the provisions of this Act.” In the AHA’s view, notwithstanding § 6’s *unlimited* grant of rulemaking authority, the NLRB may not promulgate rules defining particular groupings of employees as appropriate units.

Moreover, as Judge Posner observed in his opinion below, the AHA’s argument would apply equally “if the Board had announced the rule in an adjudicative proceeding.” Pet. App. 8a. Thus, acceptance of the AHA’s position would require overturning countless NLRB decisions delimiting appropriate units for an industry or for a subgroup of employers within an industry. See n.12 *infra*. In *add*, the logic of the AHA’s position would prevent the Board from formulating any rules which apply beyond a single case, because § 9(b), in the AHA’s view, mandates “individual case-by-case evaluation.”

In its brief, the NLRB shows that the AHA profoundly misunderstands § 9(b). The AHA’s interpretation of “in each case” is not a necessary—or even a plausible—reading of the statutory text as that language does *not* purport to address the *source of law* which is to be applied “in each case.” The AHA’s interpretation is even more implausible in light of the legislative history which shows that the point of the “in each case” language was “to prevent the Board from bringing about

a revolution in unit determinations by prescribing employer units, or craft units, or plant units for all employers under the Board’s jurisdiction.” Pet. App. 6a-7a. And the AHA’s understanding of § 9(b) is at war with the manner in which the Act has been interpreted and applied for the better part of five decades as well as with the teaching of this Court in *Labor Board v. Metropolitan Ins. Co.*, 380 U.S. 438 (1963).

The Board’s arguments are, of course, fully dispositive of the AHA’s contention. But, as we proceed to demonstrate, the AHA’s argument suffers from a second and equally fatal flaw: that argument profoundly misunderstands the nature of the decisions the Board is called upon to make under § 9. Indeed—as the AHA itself once recognized, pp. 7-8 *supra*—the AHA’s argument would lead to a regime which, in practice, would defeat the policies the Act is designed to further. For these reasons, too, the AHA’s argument should be rejected.

1. The AHA’s reliance on § 9(b) is ultimately circular. The AHA concedes, as it must, that statutory provisions like § 9(b) which require hearings or decisions “in each case” do not foreclose an administrative agency from “rely[ing] on its rulemaking authority to determine issues that do not require case-by-case consideration.” *Heckler v. Campbell*, 461 U.S. 458, 467 (1983); see AHA Br. at 21. As the Court explained in *Heckler*, “[a] contrary holding would require the agency continually to relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding.” *Id.*

It necessarily follows that § 9(b) cannot answer the question whether unit determinations require “case-by-case consideration” or whether those determinations can be “established fairly and efficiently in a single rulemaking proceeding.” That answer depends at the threshold on the nature of the issues that must be resolved to define appropriate units. The AHA’s submission at bottom rests on its posit that “[b]y their nature” unit deter-

minations—like assessments of individual abilities—“require case by case consideration” because such determinations necessarily turn on “matters of historic fact, unique to each hospital.” AHA Br. at 22 (emphasis added). As we proceed to show, the Board acted well within its discretion in reaching a contrary conclusion.

2. NLRA § 9(a), 29 U.S.C. § 159(a), provides in pertinent part that “[r]epresentatives . . . selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes shall be the exclusive representatives of all the employees in such unit.” Section 9(b), in turn, directs the Board to “decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.” And § 9(c), 29 U.S.C. § 159(c), then provides a procedure whereby a “group of employees . . . [who] wish to be represented for collective bargaining” (or an employer who has received a claim for recognition from his employees) may petition the NLRB to hold a representation election within an appropriate unit.

Under this statutory scheme the question the NLRB must decide in any given representation proceeding is whether, “in order to assure to employees the fullest freedom in exercising the[ir] rights,” the grouping of employees which is seeking representation should be deemed to constitute “a unit appropriate” for the “purpose of collective bargaining.” The Board’s “focus is on whether the employees share a ‘community of interest’” as “[a] cohesive unit—one relatively free of conflicts of interest—serves the Act’s purpose of effective collective bargaining and prevents a minority interest group from being submerged in an overly large unit.” *NLRB v. Action Automotive, Inc.* 469 U.S. 490, 494 (1985); see *Chemical Workers v. Pittsburgh Glass*, 404 U.S. 157, 172 (1971).

Of particular significance, the Act demands only that the Board determine whether a proposed unit is “an appropriate unit.” As the Board has long recognized:

Appropriate is a word with a well-defined meaning. . . . It carries with it no overtones of the exclusive or the ultimate or the superlative. To convey such thoughts, the words “only” or “ultimate” or “most” must be conjoined with the word “appropriate.” [*Morand Brothers Beverage Co.*, 91 NLRB 409, 418 n.13 (1950), *enf’d*, 190 F.2d 576 (7th Cir. 1951)]

Given the substance of the question the Board is called upon to decide, the AHA is simply wrong in contending that unit determinations must, of necessity, turn on “matters of historic fact, unique to each hospital.” AHA Br. at 22. Such historic fact would quite obviously be determinative if the Board were required to fashion the *optimal* unit in each case, as that could not be done without a detailed and case-specific assessment of all the facts and circumstances pertaining to a particular employer. But as *Morand Brothers* teaches, “There is nothing in the statute which requires that the unit for bargaining be the only appropriate unit, or the ultimate unit, or the most appropriate unit; the Act requires only that the unit be ‘appropriate.’” 91 NLRB at 418; see also, e.g., R. Gorman, *Basic Text on Labor Law*, *supra*, at 66; C. Morris (ed.), *The Developing Labor Law* 414 (2d ed. 1983).

The much broader § 9 standard the Board actually is called upon to administer—determining whether a particular grouping of employees is sufficiently “cohesive” to make that grouping an appropriate predicate for collective bargaining—does not require the same degree of particularity in decision-making. Such determinations can logically be based upon considerations that do not vary from case to case; for example, jobs can be grouped into units based upon the functions the jobs entail and the training and skills that are required to perform the jobs. And although facts specific to an em-

ployer may make a particular unit more or less appropriate in a particular case, such facts are unlikely, except in the extraordinary case, to render a "functionally distinct" unit, *Chemical Workers v. Pittsburgh Glass*, *supra*, 404 U.S. at 172, which is an appropriate unit in one workplace within an industry but inappropriate in another place in the same industry.

A few examples from the Rule itself help to make the point concrete. As previously noted, the Rule recognizes three groups of non-professionals as constituting appropriate units: medical technicians; office clericals; and skilled maintenance craft employees. As to each group, the Board found:

(1) The group performs a unique set of tasks requiring unique training and skills. Medical technicians work in the various medical laboratories performing "routine clinical tests," J.A. 123-24; office clericals work in hospital business offices and "are primarily responsible for a hospital's financial and billing practices," J.A. 150-51; and the skilled maintenance craft employees are "engaged in the operation, maintenance, and repair of the hospital's physical plant systems." J.A. 133.

(2) Within each group there are unique career paths: medical technicians may become professionals but they will not become secretaries, carpenters, plumbers or the like; business office clericals may leave the hospital industry for clerical work in another industry but they will not become technicians or craftsmen; and craftsmen move from apprentice to journeyman and from hospitals to other types of establishments, but they do not become technicians or secretaries. J.A. 128, 136-37, 155-56.

(3) Each group has relatively limited contact with the other groups. Technicians work principally with the professionals in their laboratories and have little contact with the business office or the maintenance department. The skilled maintenance employees work on the physical plant and have only "brief, limited,

and incidental" contact with other employees in the course of doing repair work. And the office clericals work within the business office which is physically isolated from the clinical units. J.A. 126, 136, 154-55.

(4) While all the groups, and indeed, all employees, share concerns over wages and benefits, each of these groups also has a unique set of labor-related concerns arising out of their unique occupations and each group historically has organized on a separate basis. Maintenance employees, for example, seek "access to craft-related education and training programs; tool supply allowances; safety equipment and practices; [and] portable pensions"; office clericals are concerned with "pay equity, performance monitoring, productivity standards, . . . automation and VDT stress." J.A. 139-40; 157-58; *see* J.A. 129-31; 138-39; 156-57.

(5) If permitted to organize separately, none of the groups is likely to develop jurisdictional conflicts with any of the other group as each group's jurisdiction is defined by the unique tasks the group performs. Nor is any of these groups likely to engage in "leap-frog" bargaining since each group has its own labor market and looks to the rate of pay within that labor market in making wage demands. J.A. 143-44, 158-59.

These considerations quite obviously are not case or employer specific; each applies across the industry and, except in an extraordinary case, is not susceptible of being rebutted on a case-by-case basis. And while the AHA complains bitterly that the Rule pretermits individualized decision making, the AHA fails to explain how, given these considerations, the "circumstances of the particular hospital," AHA Br. at 47, could, except in the extraordinary case, affect the appropriateness *vel non* of any of these three units. Thus, the Rule itself contains its own proof that the legal standard the Board is called upon to apply in unit determinations at the very least is susceptible of application across the industry.

3. Of equal importance, the policies of the Act demand that unit determinations be made across an industry. This is true for two independent reasons.

(a) The heart of the NLRA is the statutory protection granted to "the exercise by workers of full freedom of association, self-organization and designation of representation of their own choosing." NLRA § 1, 29 U.S.C. § 151. Towards that end, the Act creates the representation election procedure, described above, to facilitate employee self-determination.

The electoral system the NLRA seeks to create—like any other electoral system—presupposes an identifiable polity for whose support a campaign can be waged; the system could not work if, as the AHA supposes, the boundaries of the election unit had to be decided anew in each case based upon facts and circumstances "unique to each [employer]," p. 9 *supra*. In order for employees to be able to effectively exercise their right of self-organization they need to know when they begin their organizing campaign—and not months thereafter—which groupings of employees are (and are not) appropriate. Without such information the employees will not know who they must include (and who they may not include) in their organizing effort.⁹

By the same token, the administrative process would collapse of its own weight absent settled understandings

⁹ This is especially true in light of the fact that, under the NLRA, the Board renders its unit determinations in response to representation petitions filed by a group of employees seeking collective bargaining representation. See NLRA § 9(c), 29 U.S.C. § 159(c). Such petitions must be accompanied by a "showing of interest" that at least 30% of the employees in the proposed unit have already designated a particular union to be their bargaining agent. NLRB Casehandling Manual, Part Two § 11022.3(a). And once a unit determination is made the Board will ordinarily direct an election within thirty days of the decision (provided, of course, that the union has made a sufficient showing of interest in the unit found to be appropriate). See C. Morris, *supra* 381. Thus the statutory scheme assumes that the organizing campaign will in large part precede any unit decision by the Board.

as to the scope of appropriate units. Section 9(c) requires that before filing a representation petition, a union must seek voluntary recognition from the employer of the affected employees. But if each unit determination were to turn on the unique historical circumstances of each individual case, employers and unions alike would be genuinely uncertain as to when particular types of units are (or are not) appropriate, and one party or the other would almost inevitably deem it worthwhile to litigate in the hopes of achieving a favorable decision (or tactical advantage from the litigation process itself).

The net effect of such a regime would be twofold. First, the Board's ability to procure settlements of representation disputes—which are the "life-blood of the administrative process" generally,¹⁰ and which presently resolve 80% of all representation cases in particular—would be substantially diminished.¹¹ And second, if every contested representation case were to be treated as if the case posed a new problem to be solved by the Board *ab initio*—armed with nothing more than "general principles . . . stating the factors regional directors should weigh,"

¹⁰ Attorney General's Committee on Administrative Procedure, *Administrative Proceedings in Government Agencies, Final Report*, S. Doc. 8, 77th Cong. 1st Sess. 35 (1941).

¹¹ See Tables 9 and 11B of the various Annual Reports of the National Labor Relations Board.

Indeed, when the 1974 Amendments were before Congress the Board testified that the Agency would be able to handle the volume of work because "[o]nce the Board sets the guidelines for jurisdiction and appropriate units, employers and unions will soon agree to consent elections in about 80% of the cases." *Hearings on H.R. 11357 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 92nd Cong. 2d Sess. 50-51 (1972) (hereinafter "1972 Hearings"). In fact, the rulemaking record shows that settlements have been less common in the hospital industry than other industries, at least in part because of the uncertainty that has existed as to what hospital units are appropriate. WS Prof. Schwartz, p. 10.

AHA Br. at 19—these cases would not only grow in numbers but also would become more and more difficult for the Board's many hearing officers to adjudicate. The ultimate result would be a much more costly and time-consuming representation procedure, one in which employee self-organization would become that much more difficult.

Thus, as the AHA once acknowledged, the representation procedure the Act creates requires the "predictability" and "uniformity," p. 7 *supra*, that rules—whether formulated through rulemaking or adjudication—provide.

(b) The policies of the Act also demand a consistency in unit determinations that can be achieved only through the application of more-or-less definite unit rules.

While the NLRA seeks to protect employee free choice, its more fundamental aim is, as § 1 of the Act declares, to "encourage the practice and procedure of collective bargaining." The "evil Congress was addressing" in enacting the NLRA was the "inequality of bargaining power" which exists when unorganized workers deal with their employer one by one, and "the resultant depressed wage rates." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 754 (1985). Congress hoped to overcome these "evils" by "establishing procedures for more equitable private bargaining." *Id.*

In order for collective bargaining to be effective in achieving these ends, "employees must make their combination extend beyond one shop" and include "as many as may be in the same trade in the same community" as workers are "bound to be affected by the standard of wages of their trade in the neighborhood." *American Steel Foundries v. Tri-City Trades Council*, 257 U.S. 184, 209 (1921). Thus, the labor laws state a "strong labor policy favoring the association of employees to eliminate competition over wages and working conditions." *Connell Co. v. Plumbers & Steamfitters*, 421 U.S. 616, 622 (1975).

Under the best of circumstances, that policy—which requires a high degree of organization within a given labor market—is difficult of effectuation. But the right of employees to eliminate wage competition through collective bargaining would be a nullity if unit configurations varied from employer to employer within a unit based upon the "unique historical circumstances" of each employer. Under such a regime medical technicians, to take one example, might constitute a separate unit in one hospital, might be combined in an all-nonprofessional unit in a second hospital, and might be conjoined with the skilled maintenance craftsmen in a third. The obstacles that would be posed to eliminating wage competition among the technicians in such a world are self-evident.

4. It is this complex of considerations that, as the NLRB demonstrates in its brief, has caused the Board, in industry after industry, after acquiring sufficient experience to understand the industry's workings, to announce rules defining particular groupings of employees in the industry as appropriate or inappropriate and to thereafter follow those rules in each succeeding case. There are, for example, rules governing basic manufacturing industries; rules for the construction industry; rules for retail establishments; and rules for more specialized industries such as newspapers, public utilities, and entertainment.¹²

¹² For illustrations of these various rules see, e.g., *Chin Industries, Inc.*, 232 NLRB 176, 177 (1977) ("a production and maintenance unit normally constitutes an appropriate unit"); *Westinghouse Electric Corp.*, 118 NLRB 1043, 1047 (1957) ("it is contrary to Board policy to include office clericals in a production and maintenance unit"); *Armstrong Rubber Co.*, 144 NLRB 1115, 1119 (1963) ("the Board has consistently refused to join office and plant clerical employees in a single unit"); *Bulldog Electric Products Co.*, 96 NLRB 642, 643 (1951) ("the Board has repeatedly held that a unit of technical employees is appropriate"); *Astronautics Corp.*, 210 NLRB 650, 651 (1974) ("a unit of technical employees is inappropriate where it does not include all in that

Indeed as we discuss in great detail *infra* at pp. 23-30, the AHA's concern over "unit proliferation" when the 1974 Amendments were before Congress was fueled by rules that the Board had formulated on an industry-wide basis for certain other industries—rules which the AHA feared would be applied to the hospital industry as well. And the solution which the AHA unsuccessfully championed was to amend § 9(b) to fix certain units—which the NLRB had held to be appropriate in other industries—as the only appropriate for all health care institutions.

To be sure, in all other industries the Board has proceeded to define appropriate groupings of employees through adjudication rather than through rulemaking. That is in good measure because, as the Board explained in embarking upon this rulemaking proceeding, no agreed-upon first principles—that is, no accepted doctrinal test—had been developed to govern the health care industry that could serve as a base from which adjudication could proceed. See J.A. 5-11. But not even the AHA complains about the procedure the Board employed in this case. And as this Court has made clear "the choice between rulemaking and adjudication lies in the first instance within the Board's discretion," *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 194 (1974); see also *SEC v. Chenery Corp.*, 332 U.S. 194, 202 (1947) ("[t]o insist upon one form of action to the exclusion of the other is to exalt form over necessity").

5. One final point needs to be made. The AHA bases much of its attack on a claim that the Rule at issue here establishes "conclusive presumptions of law that apply."

category"); *R.B. Buller, Inc.*, 160 NLRB 1595, 1598 (1963) ("in the construction industry, the Board has found separate units of craft employees to be appropriate"); *Garden Island Publishing Co.*, 154 NLRB 697 (1965) (newspaper industry); *Baltimore Gas & Electric Co.*, 206 NLRB 199 (1973) (utility industry). See generally Office of the General Counsel, *An Outline of Law and Procedure in Representation Cases* (1974).

AHA Br. at 12 (emphasis added). Our discussion to this point establishes that even if this were true, it would be of no legal consequence at least so long as the Board rationally determined that "acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units" and that "the policies of the Act would better be effectuated by the establishment of appropriate units" by rule. J.A. 189.

But the reality is that the AHA mischaracterizes the Rule; as the Board stated, "the rule does not . . . conclusively establish invariable parameters of bargaining units." J.A. 187. Rather, what the Board has done is to identify the recurring factual considerations that have led the Agency to conclude that each of the employee groupings provided for in the Rule is an appropriate bargaining unit; identify the recurring factual considerations which the Board has determined are insufficient to establish the inappropriateness of these units; and then leave it open to any hospital to prove (in any given case) that the particular hospital is so situated that application of the Rule would be "accidental or unjust." J.A. 187.

In other words, the Rule does leave room for case-by-case litigation, but only with respect to matters whose legal significance the Board has not yet addressed and found insufficient to impeach the appropriateness of the units the Board has delineated. And as we have seen nothing in § 9(b) forecloses the Board from promulgating such a rule.

II. THE 1974 AMENDMENTS DO NOT IMPOSE A LEGAL DUTY ON THE BOARD WHICH WOULD PRECLUDE THE BOARD FROM PROMULGATING ITS HOSPITAL BARGAINING UNIT RULE.

In promulgating the Rule, the NLRB considered at length the significance of the so-called "admonition" contained in the committee reports accompanying the 1974 Amendments which counsels the Board to give "[d]ue consideration . . . to preventing proliferation of bargaining units."

While questioning whether the admonition is legally binding, *see* J.A. 247-48, the Board concluded that in any event the Agency had satisfied the admonition by "carefully examining the exhaustive rulemaking record" and "mak[ing] a determination . . . consistent with a requirement that these units not be likely to produce the unwanted results of repeated work stoppages, jurisdictional disputes, wage whipsawing, and other related evils." J.A. 253; *see* J.A. 78-88, 110-13, 114, 131, 145-46, 158-59, 191-94, 246-54.

Notwithstanding the Board's careful attention to this issue, the AHA argues that the Agency has failed to satisfy the obligations created by the admonition. According to the AHA, the admonition requires the Board, before deciding whether any proposed hospital unit is an appropriate unit, to "determine the impact of [the] additional bargaining unit on [the] particular hospital," taking into account such factors as the "number of existing bargaining units" and whether "approval of th[e] unit is likely to lead to proliferation of units in the future." AHA Br. at 31-32 & nn. 14-15.¹³ On this basis, the AHA contends that the admonition provides an independent basis for overturning the Rule.

We agree with the NLRB that the Agency complied with any legal requirement that could possibly be derived

¹³ The AHA nowhere explains how the Board is to make such predictive judgments on a case-specific basis (other than to advance the remarkable suggestion that greater latitude should be afforded to the first group of employees in a hospital to organize than to any succeeding group). The reality is, as the Board observed in promulgating the Rule, that one of the advantages of rulemaking in this context is precisely to allow "past experience in the industry generally" to be considered in assessing the likely impact of upholding a proposed unit, "whereas under adjudication, whether strikes, whipsawing, or jurisdictional disputes will result if an initial organizing effort succeeds carries with it a greater degree of speculativeness" since "under adjudication of individual cases, no evidence whatever [in these regards] can be adduced as to the facility under considerations." J.A. 252.

from the legislative history of the 1974 Amendments. But it is our primary submission that, because the "admonition and the remarks addressed to it were divorced from the legislation then before Congress they are an illegitimate source of authority" for imposing obligations on the Board. *Electrical Workers Local 474 v. NLRB*, 814 F.2d 697, 717 (D.C. Cir. 1987) (Buckley, J., concurring).

Ironically, the best proof of the legal error that infects the AHA's submission lies in the legislative materials themselves. For once the legislative history is fully understood—and the half-truths and misstatements in the AHA's presentation of those materials corrected—it becomes readily apparent that the legislative history on which the AHA relies is not and cannot be a source of legal obligation. We thus begin with a detailed review of the legislative history of the 1974 Amendments and then address the legal significance of that history.

A. The Legislative Materials.

1. By the time the 1974 Amendments were being considered by Congress, there was a substantial body of experience and law with respect to the formulation of bargaining units in hospitals. The NLRA itself applied to proprietary or for-profit hospitals and nursing homes.¹⁴ Moreover, thirteen states had elected to confer organizational rights on hospital employees as a matter of state law.¹⁵ And there were even a few areas of the country—most notably California—in which, as of 1974, it was common for hospital employers, absent any legal requirement, to agree voluntarily to bargain collectively with their employees at the employees' request.¹⁶

¹⁴ *See Butte Medical Properties*, 168 NLRB 266 (1967); *cf. University Nursing Homes*, 168 NLRB 263 (1967) (proprietary nursing homes).

¹⁵ Federal Mediation and Conciliation Service, *Impact of the 1974 Health Care Amendments to the NLRA on Collective Bargaining in the Health Care Industry* 33 (1979).

¹⁶ *See* 1972 Hearings at 157 (125 California hospitals have "had experience in collective bargaining" as of 1972).

Although many of the hospital bargaining units which were formed pre-1974 were of the type now permitted by the Rule, *see* J.A. 102-03, 129-30, 137-38, 156-57, there were a significant number of hospitals in which the employees had formed far narrower and more specialized units divided along professional, departmental, or craft lines. For example, the New York Labor Relations Board had recognized no less than 21 separate bargaining units for hospital employees including pharmacists, social workers, dieticians and "so on among the professionals, quasi-professionals and para-professionals found in hospitals."¹⁷ In California there were similarly separate units for various professions, technical specialties (such as x-ray technicians, laboratory technicians, and vocational nurses), maintenance crafts (such as painters and engineers), and unskilled departments (such as kitchens, housekeeping and laundry units).¹⁸ And the NLRB, in its pre-1974 decisions involving proprietary hospitals, had permitted separate units for various discrete professional and technical groups such as pharmacists, *Syosset General Hospital*, 190 NLRB 304 (1971), radiologic technologists, *Ochsner Clinic*, 196 NLRB 10 (1972), and LPNs, *Silver Lake Nursing Home*, 178 NLRB 478 (1969).

It was against this background that Congress considered the issue of appropriate units in the course of enacting the 1974 Amendments.

2. As the AHA observes, the 1974 Amendments were the culmination of a "legislative process that lasted two years." AHA Br. at 3. The proliferation issue was not injected into that process until after the House of Representatives had overwhelmingly approved a bill sponsored by Representatives (Frank) Thompson and (John)

¹⁷ 1972 Hearings at 300.

¹⁸ *Hearings on S. 794 Before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare*, 93rd Cong. 1st Sess. 199-200 (1973) (hereinafter "1973 Hearings").

Ashbrook, the chairman and ranking minority member of the House Special Labor Subcommittee, and backed by the Nixon Administration, *see* 1972 Hearings at 70-71, to extend the NLRA *in toto* to non-profit hospitals.

When that bill reached the Senate Labor Committee, the hospital industry, led by the AHA, mounted an eleventh-hour defense. The AHA argued that for two basic reasons, the NLRA was "inappropriate for application to the health care field." 1972 Hearings at 33 (testimony of David Hitt). "The first involves strikes, picketing and impasses. The second pertains to the fragmentation and proliferation of bargaining units." *Id.*

With regard to the latter objection, the AHA argued that the workforce of hospitals generally is divided into "over 100 separate occupational classifications with an overwhelming number being critical to the efficient operation of hospitals." *Id.* at 34. Referring specifically to the NLRB's proprietary hospital unit decisions, *see id.* at 35, the AHA argued that left unchecked the Board would follow the same rules throughout the hospital industry and allow separate units "for many other professional and paraprofessional groups as well as for the many crafts," *id.* at 35.¹⁹

The AHA's arguments sufficiently concerned Senator Robert Taft Jr. that the Senator blocked final action on the health care bill in the Ninety-Second Congress.²⁰

3. When the Ninety-Third Congress convened in 1973, Representatives Thompson and Ashbrook reintroduced their bill to extend the NLRA to non-profit hospitals, and Senators Cranston and Javits introduced the identical bill

¹⁹ *See also* 1972 Hearings at 155-56 (Minnesota Hospital Association), 169-71 (California Hospital Association), 208 (Texas Hospital Association), 238-39 (Ohio Hospital Association). It is noteworthy that neither the AHA nor any of its state affiliates had any difficulty in 1972 generalizing about the hospital industry or in discerning the general unit rules that apply in other industries.

²⁰ *Hospital Progress*, October, 1972, p. 21.

in the Senate. H.R. 1236, S. 794, 93rd Cong. 1st Sess. (1973), reprinted in *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974* at 445, 448 (hereinafter "Leg. Hist."). Senator Taft introduced a separate bill to extend NLRA coverage to non-profit hospitals with amendments establishing special rules for such hospitals. S. 2292, 93rd Cong. 1st Sess., Leg. Hist. at 449-61. Thus, by the time the 1973 hearings began it was clear, as Senator Taft observed, that the "basic question" was no longer "whether coverage of the NLRA should be extended to non-profit hospitals" but rather whether and to what extent special provisions should be added to the Act to govern hospitals. 1973 Hearings at 75.

That being so, the AHA and all of the state hospital associations testifying in 1973 supported the Taft bill.²¹ The Taft bill contained two provisions that were especially welcome to the hospital industry.

First, to deal with the issue of work stoppages which the AHA had raised, the Taft bill prohibited strikes in the health care industry during a mandatory four-month "cooling off period" following the expiration of every bargaining agreement, and the bill also made it unlawful for a health care union to strike or picket absent a secret ballot referendum vote authorizing such action. Second, to deal with the "proliferation" issue, the Taft bill fixed the appropriate bargaining units in health care institu-

²¹ See 1973 Hearings at 143-49 (AHA proposal identical to Taft bill); 161 (Iowa Hospital Association); 169 (Colorado Hospital Association); 177 (Texas Hospital Association); 187 (California Hospital Association); 438 (New Jersey Hospital Association); 441 (Minnesota Hospital Association); 443 (Ohio Hospital Association).

The AHA is thus simply wrong in claiming in its brief to this Court that in 1973-74 "much of the industry opposed altogether any repeal of the exemption [of non-profit hospitals from the NLRA]," and in viewing the ultimate legislation that was enacted as "a compromise between those who favored repeal of the hospital exemption and those who opposed repeal." AHA Br. at 33-34 n.18.

tions. Both of these provisions were derived, verbatim, from language which the California Hospital Association had proposed towards the close of the 1972 Hearings and which the AHA had endorsed. See 1972 Hearings at 173-78, 159.²²

In its testimony in 1973, the hospital industry championed the Taft bill on much the same grounds it had opposed the 1972 bill to extend the NLRA's coverage to hospitals. With respect to the unit proliferation issue, the AHA and its allies continued to define their concern by referring to the NLRB's decisions involving proprietary hospitals and by expressing the fear that, left unchecked, the NLRB would create a large number of small, single-specialty or crafts units in hospitals.²³

Organized labor vigorously opposed the Taft bill, arguing that it was improper to "establish[] different procedures for nonprofit hospitals than for other business establishments," and that the Labor Board was fully able to develop special rules for the hospital industry which would take account of "the special characteristics which distinguish the hospital industry from other industries" just as the Board had "dealt with that problem in other industries."²⁴ The Nixon Administration concurred, testifying that

²² In commentary to its proposal, the California Hospital Association had observed, in explaining the proposal for an office clerical unit, that "the Board does not combine office clericals with other employees if either party objects." 1972 Hearings at 178. The AHA made the same observation in 1973. See 1973 Hearings at 148. This is further evidence that in 1972-73 the hospital industry was well aware of the various unit rules followed by the NLRB.

²³ 1973 Hearings at 139 (AHA); 160-61 (Iowa Hospital Association); 175 (Colorado Hospital Association); 181 (Texas Hospital Association); 188 (California Hospital Association); 465 (Ohio Hospital Association).

²⁴ 1973 Hearings at 562, 564 (testimony of Andrew Biemiller, Legislative Director of the AFL-CIO); see also *id.* at 49, 60, 286.

In the long run, the only thing that prevents strikes is the establishment and maintenance of a good collective bargaining climate. And we believe that the best way to assure that kind of climate is by covering employees in the private health care field under the NLRA in essentially the same way that employees in other industries are covered. [1973 Hearings at 428; testimony of Undersecretary of Labor Richard Schubert]

With particular regard to the unit determination issue, Undersecretary Schubert added: "We agree that unwise unit determinations could be harmful, but we see no reason to anticipate such action by the Board." *Id.* at 427. The only amendments to the NLRA which the Nixon Administration supported were "limited safeguards" proposed "to assure the greatest participation possible of the Federal Mediation and Conciliation Service." *Id.* at 428-29.²⁵

4. When the Senate Labor Committee concluded its hearings in October, 1973, Senator Taft's staff arranged a series of meetings between representatives of the hospital associations and of organized labor. Through those negotiations a "compromise was struck."²⁶ The hospital

²⁵ In its brief to this Court, the AHA asserts that the Taft bill "was opposed as overly rigid and unduly restrictive of the Board's flexibility to determine bargaining units on a case-by-case basis taking into account the particular situation at each hospital." AHA Br. at 27. As the quotations in text prove, the AHA's characterization has nothing to do with what the opponents of the Taft bill—both from labor and from the administration—actually said. Indeed, it is noteworthy that the only citation the AHA offers to support its assertion is to a speech by Senator Dominick, who was aligned with the AHA—and not with the Taft bill opponents—in 1973-74.

²⁶ Pointer, *The 1974 Health Care Amendments to the National Labor Relations Act*, 26 Labor Law J. 350, 355 (1975). See also Leg. Hist. at 91 (Sen. Cranston), 256 (Senator Taft), 288, 387 (Rep. Thompson).

The AHA contends that because the original Taft bill was never voted upon, no inference can be drawn from the fact that the bill

industry gave up its quest for a four-month cooling off period following contract expiration, for mandatory strike votes, and for a statutory restriction on the number of health care bargaining units. In return, organized labor accepted the Nixon Administration's proposed special rules for involving the FMCS in labor disputes in the health care industry.²⁷ The compromise bill was introduced by Senator Taft as a substitute for his original bill. S. 3088, 93rd Cong., 2d Sess. (1974), Leg. Hist. 462-65.

In addition to the text of the bill itself, the AHA and union negotiators developed what Senator Taft referred to as "agreed-upon . . . report language," Leg. Hist. at 112, which addressed issues not dealt with in the bill itself. Thus, in the Senate Committee Report—right after the section entitled "Provisions of the Bill" which explains the statutory provisions in the compromise bill, see S. Rep. 93-766, 93rd Cong., 2d Sess. 3-5, Leg. Hist. 10-12—there is a lengthy additional section, entitled "Effect on Existing Law," which sets forth agreed-upon views as to how the NLRB should apply existing and unamended provisions of the NLRA in health care cases, see *id.* at 5-7, Leg. Hist. at 12-14. The admonition to give "[d]ue consideration . . . to preventing proliferation of bargaining units" is contained in this section of the Report. *Id.* at 5, Leg. Hist. at 12. The exact same words appear in a section of the House Report entitled "Effect on Existing Law—Bargaining Units." H.R. Rep. 93-1051, 93rd Cong., 2d Sess. 6 (1974), Leg. Hist. at 274.²⁸

failed of enactment. See AHA Br. at 27-28 n.12. But surely it is of note that the proponents of the Taft bill, in order to secure the votes needed to enact any special rules governing the health care industry, traded away the provision of the Taft bill establishing bargaining unit rules.

²⁷ These rules are now codified in NLRA § 8(d), (g), 29 U.S.C. § 158(d), (g).

²⁸ The full text of the admonition is reprinted in petitioner's brief at p. 5.

The compromise bill was reported out of the Senate and House Labor Committees without material change. Senator Dominick dissented, stating that while he "appreciate[d] Senator Taft's work as a conciliator," the compromise was nonetheless inadequate. S. Rep. 93-766, *supra*, at 39, Leg. Hist. at 46. In particular, Senator Dominick argued that the unit determination issue "merits specific statutory language" because, in his view, a "hospital should be protected by statute from being placed in a position of continual bargaining with different units." *Id.* at 45, Leg. Hist. at 52.

On the floor of the Senate, Senator Taft attempted to put the best possible face on the compromise. In words that closely paralleled the arguments the AHA had made, Senator Taft observed that hospitals generally are "vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients." Leg. Hist. at 113. Senator Taft continued:

If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. * * * *Health care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.* [Leg. Hist. at 113-14; emphasis added ²⁰]

²⁰ The AHA's brief omits the italicized words from its quotation of Senator Taft's speech. See AHA Br. at 28-29.

Senator Taft's reference to the construction industry reflected arguments the Ohio Hospital Association had made in the 1972 Hearings:

Like construction and newspapers, also relatively-labor intensive, hospitals are divided into many high specialized crafts, each of which has a vital role in the team effort. The legislation which you are now considering has contributed to fractionation and multiple craft negotiation in construction and newspapers. [1972 Hearings at 238-39]

The AHA asserts that the hospital industry and Senator Taft cited the construction and newspaper industries as "extreme ex-

B. The Lessons.

1. The most salient point that emerges from the legislative materials is this: in enacting the 1974 Amendments Congress made a quite deliberate decision *not* to legislate with respect to hospital unit determinations but rather to leave unchanged the Board's discretionary authority over unit determinations under NLRA §§ 6 and 9.

The 1974 Congress had before it proposals to amend the NLRA in various respects by adding a series of special rules to govern health care institutions, including a proposal to enact special rules governing health care bargaining unit determinations. Congress in fact enacted two special health care provisions, the "notice-of-contract-expiration" and "notice-of-strike" provisions contained in NLRA §§ 8(d), (g). See p. 29 *supra*. But the advocates of the special health care bargaining unit provision *failed* in their effort to secure the enactment of that provision, and their proposal was dropped as part of the compromise which led to the enactment of these notice provisions. Thus, NLRA § 9, the section which establishes the NLRB's authority to determine appropriate bargaining units, was left unchanged.

In this context, the fair inference is precisely the one this Court drew in *Beth Israel Hospital v. NLRB*, *supra*, 437 U.S. at 392, with respect to another claim by hospitals for special NLRA treatment: "We can only infer that Congress was satisfied to rely on the Board to continue to exercise the responsibility to strike the appropriate balance between the interests of hospital employees, patients, and employers." And that inference is especially

amples of proliferation," but that this "hardly means that their concerns were limited to avoiding those extremes." AHA Br. at 34. As the review of the legislative materials makes clear, however, at no point in the legislative process did the AHA or its allies hint at any concern other than avoiding single craft or single occupation units. It is therefore not surprising that the AHA is unable to offer a single citation to the legislative record to support its assertion.

strong here because § 9(b) does contain certain other limitations on the Board's discretion in shaping units, thus establishing that "Congress knows how to limit the board's discretion to define collective bargaining units." *NLRB v. Action Automotive Inc.*, *supra*, 469 U.S. at 497. As the Court added in *Action Automotive*: "We are not authorized to bind the Board in ways not mandated by Congress." *Id.*

For this reason alone, the 1974 Amendments cannot be understood to impose any legal obligations upon the Board with respect to unit determination, and can provide no independent basis for overturning the Rule.

2. Although the reasoning of *Beth Israel* is compelling, it is not necessary to rely on an "inference" concerning Congress' intent in deciding the instant case. For regardless of whether the 1974 Congress was satisfied or dissatisfied with the Board's administration of § 9 over the years and regardless of what that Congress may have thought about appropriate hospital bargaining units, the 1974 Congress *did nothing to translate its sentiments into positive law*. And it is only through statutes—and not through expressions of intent divorced from any statutory reference point—that the Legislature can impose legal obligations on an administrative agency such as the NLRB.

This Court has on numerous occasions held that one Congress cannot alter the meaning or effect of a statutory provision duly enacted by a prior Congress merely by expressing dissatisfaction with or a new understanding of the provision; this is true even when the subsequent Congress expresses its views in the course of either reenacting the law, *e.g.*, *Pierce v. Underwood*, 487 U.S. 552, 566-67 (1988), or amending other provisions of the same law, *e.g.*, *United States v. American College of Physicians*, 475 U.S. 834, 846-47 (1986); *Oscar Mayer Co. v. Evans*, 441 U.S. 750, 758 (1979); *Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772,

788 (1981). Most recently, the Court made the point in *Public Employees Retirement System v. Betts*, — U.S. —, 57 L.W. 4931 (June 23, 1989), a case which is analytically indistinguishable from the instant case.

Betts involved the interpretation of § 4(f)(2) of the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 623(f)(2) ("ADEA"), the section of that Act which permits employers to make age-based distinctions pursuant to a "bona fide employee benefit plan . . . which is not a subterfuge to evade the purposes of [the ADEA]." In 1978 Congress amended that section by adding the following proviso: "except that . . . no such employee benefit plan shall require or permit the involuntary retirement of any individual because of . . . age." Congress did so in order to overturn the holding of *United Air Lines v. McMann*, 343 U.S. 192 (1977), in which this Court had held that a bona fide pension plan which predated the enactment of the ADEA could not be a "subterfuge" to evade ADEA and that retirements required by such a plan were lawful.

The committee reports accompanying the 1978 ADEA amendment—and the statements of the sponsors of that amendment during the floor debates—expressly condemned *McMann's* reasoning (as well as its result), "particularly its [*McMann's*] conclusion that an employee benefit plan which discriminates on the basis of age is protected by section 4(f)(2) because it [the plan] predates the enactment of the ADEA." *Betts*, 57 L.W. 4933, quoting, 124 Cong. Rec. 7881.

Notwithstanding this explicit congressional criticism of *McMann*, the Court in *Betts* could find "no reason to depart from our holding in *McMann* that the term 'subterfuge' is to be given its ordinary meaning, and that as a result an employee benefit plan adopted prior to enactment of the ADEA cannot be a subterfuge." 57 L.W. at 4933-34:

The 1978 amendments of the ADEA did not add a definition of the term "subterfuge" or modify the language of § 4(f)(2) in any way, other than by inserting the final clause forbidding mandatory retirement based on age. We have observed on more than one occasion that the interpretation given by one Congress (or a committee or member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. Congress changed the specific result of *McMann* by adding a final clause to § 4(f)(2), but it did not change the controlling, general language of the statute. *As Congress did not amend the relevant statutory language, we see no reason to depart from our holding in McMann. . .* [57 L.W. at 4933; emphasis added.]

The instant case follows *a fortiori* from *Betts*. In *Betts*, the later Congress had amended the section—indeed the very sentence—of the ADEA at issue in the case. The *Betts* Court nonetheless concluded that to the extent the views of the later Congress went beyond the scope of the amendment which that Congress had enacted, the views were not authoritative guides to interpreting the ADEA.

In this case, the 1974 Congress did not amend any part of NLRA § 9, the statutory provision governing the determination of appropriate bargaining units; indeed, as noted above, that Congress expressly decided *not* to do so. It necessarily follows from *Betts* that the 1974 Congress' views as to the rules the Board should apply in administering § 9—which was enacted more than twenty-five years earlier—carry no weight in ascertaining the scope of the Board's § 9 authority.³⁰

³⁰ The court below, in concluding that the admonition is authoritative, posited that by "changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words." Pet. App. 11a-12a. But that statement begs the very question at issue: whether Congress can change the "mean-

3. Our showing to this point establishes that because the admonition represents, at most, views of a "subsequent" Congress which views were not enacted into law, the admonition cannot be said to impose any guiding obligations on the Board. There is yet a further fallacy in the AHA's reliance on the admonition: even if it were a contemporaneous expression of the view of the Congress that enacted § 9, the admonition still would be of no legal weight. For the admonition, by its very terms, relates "not to the meaning of the statute but to the manner in which a legally unconstrained [agency] will behave under [the statute]," and, it is "absurd—indeed lawless—to give legal effect" to such expressions. *Center for Auto Safety v. Peck*, 751 F.2d 1336, 1351 (D.C. Cir. 1985) (Scalia, J.). A brief elaboration of this point is in order.

The starting point for analysis is the recognition that, as Judge Friendly observed, the aim of statutory interpretation is to ascertain "what Congress meant by what it said, rather than . . . what it means *simpliciter*."³¹ Legislative history's invaluable contribution is to illuminate the meaning of statutory texts. As Judge Easterbrook has observed it is naive to believe that "words have meanings divorced from their contexts—linguistic, structural, functional, social, historical." *In re Sinclair*, 870 F.2d 1340, 1342 (7th Cir. 1989).³²

ing" of a preexisting statutory provision without changing the statutory text. *Betts* compels a negative answer to that question.

Indeed, if anything this is the last case in which legislative history alone should be allowed to change the meaning of preexisting law. What the 1974 Amendments did was to apply an existing statute—the NLRA—to a set of employers previously excluded from the Act. Surely in this context if Congress wishes different rules to apply to the newly-covered entities than apply to all other entities it is incumbent upon the legislature to enact those rules into positive law.

³¹ Friendly, *Mr. Justice Frankfurter and the Reading of Statutes*, in *Benchmarks* 218-19 (1967).

³² Judge Easterbrook continues:

To decode words one must frequently reconstruct the legal and political culture of the drafters. Legislative history may be

The admonition which is at issue here, however, does not purport to speak to, or shed any light on, the meaning of the statutory text. Section 9(b) bears quoting again:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.

The admonition does not address these words but (at most) states a consideration which Congress wished—but did not mandate—the Board to “consider” in a certain category of cases. The admonition thus may conceivably offer some insight into how (the 1974) Congress “expected . . . the [agency] to behave,” but the admonition says nothing about how Congress “required [the agency] to behave through the only means by which it can (as far as the courts are concerned at least) require anything—the enactment of legislation.” *Auto Workers v. Donovan*, 746 F.2d 855, 860 (D.C. Cir. 1984) (Scalia, J.). Thus, even if the admonition were a contemporaneous expression of the views of the Congress that enacted § 9(b), the admonition could not aid in the interpretation of the statute or impose independent duties on the Board.

For each of these reasons, then, the admonition provides no basis for overturning the Rule.³³

invaluable in revealing the setting of the enactment and the assumptions its authors entertained about how their words would be understood. It may show, too, that words with a denotation “clear” to an outsider are terms of art, with an equally “clear” but different meaning to an insider. . . . These we take to be the points of cases . . . holding that judges may learn from the legislative history even when the text is “clear.” Clarity depends on context, which legislative history may illuminate. [870 F.2d at 1342]

³³ We leave it to the NLRB to demonstrate that, if the admonition were authoritative, the Rule fully satisfies any obligations that

III. THE BOARD DID NOT ACT ARBITRARILY OR CAPRICIOUSLY IN PROMULGATING THE RULE.

As its final contention the AHA repeats the tired refrain of parties displeased by administrative action: the Rule, says the AHA, is “arbitrary and capricious.”³⁴ Specifically, the AHA argues that—notwithstanding its own prior position, *see pp. 7-8, supra*—“it was folly for the Board even to try to develop a rule that would designate specific bargaining units in the industry . . . because the great diversity in the industry makes such an approach inherently arbitrary and capricious.” AHA Br. at 40.

the admonition could be said to impose. We would add only the following:

1. The AHA’s attempt to transform the admonition into a requirement of case-by-case decision-making turns the legislative history on its head. “Proliferation” was a term of art in 1974 referring to the pattern of craft units which prevailed in the construction and newspaper industries and which, because of the state-law and proprietary-hospital decisions, the AHA feared would obtain in the hospital industry as well. To avoid that result, the AHA sought special, industry-wide rules which would be responsive to characteristics common to the hospital industry. Those opposing the AHA argued that the Board could develop rules that accommodated the realities of the industry without special statutory provisions. That position prevailed in Congress. There is no way to draw out of this a mandate to proceed without such guiding rules.

2. The AHA’s thesis is equally faithless to the political realities that led to the crafting of the admonition. In 1974 AHA abandoned its quest for major NLRA amendments in connection with the legislation covering hospitals to secure, through negotiations with organized labor, limited safeguards regarding strikes. In this context, to read the admonition as the AHA does would transform its mild, agreed-upon words into a legal requirement far more drastic than any of the modest health care rules Congress actually legislated, and would turn the admonition into a victory for the hospital industry far more sweeping and significant than that which the industry won in the areas in which the industry actually secured a legislated provision effecting a statutory change.

³⁴ The AHA goes further and argues that the Rule is “not supported by substantial evidence.” That, of course, is not the test for rules promulgated through informal (notice and comment) rule-making. *See American Power Institute v. American Electric Power*, 461 U.S. 402, 412 n.7 (1983).

Insofar as the AHA bases its attack on supposed inconsistencies between the findings underlying the Board's decision to engage in rulemaking and prior findings by the Board, we leave it to the NLRB to demonstrate the errors in the AHA's submission. For our part we, as participants in the rulemaking proceeding, focus on the great mass of evidence that was submitted to justify proceeding by general rule.

1. At the threshold, it is important to bear in mind that the Rule applies not to all health care institutions and not even to all hospitals, but rather only to private acute care hospitals which are not primarily psychiatric hospitals or rehabilitation hospitals. J.A. 259, 261. Even among such hospitals there are, of course, various differences; in the nature of things, as the Board observed, no two institutions are identical in all respects. J.A. 187. The relevant question, however, as the Board correctly stated, is not whether diversity exists but whether that diversity is "sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate bargaining units for acute care hospitals in all but truly extraordinary facilities." J.A. 57-58.

In approaching that question it is very much to the point that, as Judge Posner observed below, any rule necessarily results in a "loss in individualized justice." Pet. App. 15a. The very essence of a rule is to "make[] one or a few of a mass of particulars legally decisive, ignoring the rest"; doing so avoids "the disadvantages of discretionary justice" and achieves a "gain in certainty, predictability, celerity, and economy" *Id.* "Often the tradeoff is worthwhile." *Id.* And the "decision how much discretion to eliminate from the decisional process is itself a discretionary judgment, entitled to broad judicial deference." *Id.* at 16a.³⁵

³⁵ See also Justice Scalia's Holmes lecture, *supra*, 56 U. CHI. L. REV. at 1177-87 (acknowledging that "perfect justice can only be

Thus, the dispositive question here is whether the Board reached an arbitrary or capricious conclusion in deciding that the hospitals covered by the Rule are sufficiently alike in terms of their employee groupings so as to justify trading off the opportunity for more "individualized justice" to achieve the justice inherent in adjudicating cognate questions with certainty and predictability. It is to that question that we now turn.

2. The record establishes that the hospitals covered by the Rule share many characteristics in common. Over 95% are general medical and surgical hospitals. Furthermore, the bulk of what these hospitals do is to provide inpatient care in medical, surgical, pediatric, obstetric, and intensive care units. J.A. 53.

Moreover, the rulemaking record establishes that: in virtually every acute care hospital there are certain discrete functions that must be performed, ranging from maintaining the physical plant to caring for the patients; in the nature of things—and by operation of the various accreditation and licensing laws—these various functions require discrete sets of skills and training; and therefore in virtually every hospital there are a discrete group of employees holding a discrete group of jobs each of which encompasses distinct functions.

Put more concretely, and with specific reference to the Rule at issue here, virtually every hospital employs (or uses the service of): skilled craftsmen to maintain the plant's systems; business office clericals to handle billing and collections; medical technicians to perform paraprofessional patient care functions; registered nurses to provide around-the-clock monitoring and care; and physicians to prescribe and direct the treatment of patients.³⁶

achieved if courts are unconstrained by . . . imperfect generalizations" but arguing that nonetheless "the law of rules [should] be extended as far as the nature of the question allows").

³⁶ The only grouping which the AHA appears to challenge in general terms is the separation of technical employees from skilled

We have already observed with respect to the nonprofessional units permitted by the Rule that the considerations which led the Board to recognize medical technicians, business office clericals, and skilled maintenance craftsmen as appropriate groupings relate to the nature of the tasks those groups perform, and that those considerations are in no sense hospital-specific. See pp. 14-15 *supra*. The same is true with respect to the two professional groups the Rule permits to organize separately from all other professionals. With respect to RNs, the Board summarized the rationale for a separate unit as follows:

The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern.

The industry has contended that adverse consequences would follow having separate RN units, such

maintenance employees; the AHA argues that this is "[p]erhaps the most telling example"—of what is unclear—because "many of the factors the Board used to distinguish technical employees from service and maintenance workers . . . were used . . . to distinguish skilled maintenance employees from other service and maintenance workers." AHA Br. at 45.

It is, of course, true, that both medical technicians and skilled craftsmen are distinguishable from the unskilled employees (such as those in hospital kitchens and laundries) in that both technicians and craftsmen require special education, skills, and licenses and each group works apart from the unskilled service and maintenance workers. But technicians and craftsmen are equally distinguishable from each other by virtue of their tasks, training, interests, and markets. See pp. 14-15 *supra*. Thus, the fact that these two groups are allowed separate units is, indeed, a "telling example"—of the Board's commendable sensitivity to the discrete, natural functional groupings that exist in hospitals.

as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities. [J.A. 116-17]

And with respect to physicians the Board found:

Doctors have considerably more training than other professionals . . . Doctors have the singular responsibility of directing all other patient care employees . . . [D]octors earn substantially more than other professionals . . . Supervision of doctors is limited and is generally done by other doctors . . . [D]octors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions. They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime etc, and are outnumbered by nurses at a ratio of at least 15:1. We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed. [J.A. 118-19]

Plainly, then, it is possible to generalize about employee groupings within the hospitals covered by the Rule. Indeed in the course of its own business operations, the AHA has done just that: the AHA has found it useful to publish a book entitled "Hospital Departmental Profiles" providing "capsule descriptions of key hospital departments," AFL-CIO Ex. 11, and a second volume entitled "Health Care Occupation" which contains descriptions of hospital positions grouped by "typical departments in moderate to large health care corporations," International Union of Operating Engineers Ex. 1, p. 2.

3. The rulemaking record proves as well that the generalizations on which the Board relied in promulgating the Rule apply notwithstanding the variations that do exist within the industry, such as differences among hos-

pitals in size, range of services provided and the like.³⁷ Space does not permit us to review the record evidence with regard to each of the units allowed by the Rule; we thus concentrate on the two units that were the focus of the greatest attention at the rulemaking hearings, RN units and skilled maintenance units.

(a) In finding that RN units are appropriate across the range of acute care hospitals, the Board drew upon a wealth of record evidence. In the course of the rulemaking proceeding, more than fifteen practicing RNs—from hospitals large and small, urban and rural, and everything in between—presented evidence regarding their practices, experiences, and hospitals.³⁸ In addition, RNs from nine state nurses associations, and from several national unions which represent nurses, testified not only from their own personal experiences as practicing nurses but, moreover, from their experiences in working with and representing nurses at literally hundreds of hospitals of all sizes, shapes, and kinds.³⁹ And all of this

³⁷ It is worth noting that, in the course of the rulemaking proceeding, the Board canvassed its own decisions and found virtually no divergence in the results the Board had reached from case to case. For example, prior to adopting a "disparity-of-interests" test the Board found RN units appropriate in 24 of 25 cases; technical units appropriate in 18 of 18 cases; and business office clerical units appropriate in 18 out of 18 cases. J.A. 55-56.

³⁸ At the Chicago hearing, Jacquie Luoma, Lana Bachus, and Lelani Castro testified, Tr. I: 81-147; in San Francisco, Margaret Schauer, Lois Roth, and Linda Liperi testified, Tr. 3114-32, 3694-3705; and in Washington, the Board heard from Valerie Gonzalez and Ruth Korn, Tr. 4350-72, 4855-93. In addition, the American Nurses Association submitted written testimony from eight RNs working at locations remote from the hearings. See Submissions of Rhonda Crump, Wilma Jones, Dana Long, Nancy Pashby, Maryann Roylo, Lora Sharon, Carol Soltis, and Terry Stevens.

³⁹ See D.C. Tr. 50-79 (Karen Ballard, New York Nurses Association), 83-114 (Barbara Lumpkin, Florida Nurses Association); 122-37 (Ann Twomey, Hospital Professionals and Allied Employees of New Jersey); Chi. I. Tr. 46-81 (Karen Patek, Minnesota Nurses Association); Tr. 3102-14 (Marilyn Chow, California Nurses Association).

evidence was buttressed by the testimony of five expert witnesses who have extensively studied the nursing profession throughout the nation.⁴⁰

This evidence establishes that "[i]n every facility that delivers health care," RNs alone serve in round-the-clock shifts (D.C. Tr. 75; Ballard), and are "in constant and continuous contact with acutely ill patients, 24 hours a day, seven days a week," Tr. 3139-40 (Prof. Fine). Moreover, RNs alone are responsible for constantly monitoring patients and ensuring that all physicians' orders are carried out and that diagnostic procedures do not harm the patient. Tr. 4627-30 (Prof. Bullough). "[T]he setting in which a professional nurse practices does not alter the nurse's basic practice." D.C. Tr. 52 (Ballard); see Tr. 3135 (Prof. Fine). This is so because the unique duties and responsibilities of RNs are mandated by licensure, accreditation standards, hospital and nursing codes, and public law. See, e.g., D.C. Tr. 55-57 (Ballard); Tr. 3105-07 (Chow); 3119-20 (Schauer); 3140 (Fine); and 4665-66 (Rosen).

The record also establishes that, despite variations among hospitals: (1) RNs uniformly have little functional interaction with non-nurse professionals, see, e.g.,

tion), 3576-94 (Kathy Sackman, United Nurses Association for California), 3622-48 (Katherine Schmidt, Oregon Federation of Nurses), 4372-92 (Candice Owley, Chairperson, Federation of Nurses and Health Professionals, AFT), 4674-92 (Sondra Clark, RN Coordinator, National Union of Hospital and Health Care Employees), 4892-4920 (Anna Gilmore, Maine Nurses Association), 4920-68 (Gene Shepard, Ohio Nurses Association).

⁴⁰ See Tr. 3133A-58 (Prof. Ruth Barney Fine, Director of the Graduate Program in Nursing Administration, University of Washington), 3594-3622 (Prof. Faith Reiersen, Coordinator of Nursing Programs, Olympic College), 4617-59 (Dr. Bonnie Bullough, Dean of the School of Nursing, State University of New York at Buffalo), 4660-74 (Dr. Sumner Rosen, Professor of Social Policy, Labor Market Analysis, and Labor Management Relations, Columbia University), 5703-04 (Dr. Daniel Cornfield, Associate Professor of Sociology, Vanderbilt University).

WS Foley at 6-9; Tr. 3117-18 (Schauer), 3638-41 (Schmidt), 4387-88 (Owley), but do maintain close contact with each other in patient care, D.C. Tr. 62-63 (Ballard), 89 (Lumpkin), Tr. 3154-55 (Schauer), 3493 (Emanuel), 3680 (Indelicato), 3731-32 (Ratner); (2) RNs uniformly have a separate supervisory structure within hospitals and report to the director of nursing, D.C. Tr. 67-68 (Ballard), Tr. 3197, 3259 (Dauner), 3680 (Indelicato), 3703 (Lipari), 4910 (Gilmore); (3) RNs constitute a distinct labor market so that when they bargain about wages they look to the wages earned by RNs at other hospitals and not at the wages of non-RN nurse professionals, Chi. I Tr. 78-79 (Patek), Tr. 3155-56 (Schauer), 3316-18 (Absalom), 4356 (Gonzalez), 4888 (Korn), 4917-18 (Gilmore), 4959-60 (Shepard); and (4) many bargaining issues are of unique concern to nurses such as staffing levels, nursing practice committees, scheduling, and "clinical ladders" which allow nurses opportunities for advancement, AFL-CIO Ex. 4 at ii; WS Ballard at 11, D.C. Tr. 63 (Ballard), Chi. Tr. I 145-46 (Bachus), Tr. 3109-12 (Chow), 3291 (Absalom).

The evidence establishing these facts was, in the main, produced at the rulemaking hearings by witnesses subject to full cross-examination and rebuttal by the AHA which, along with a variety of state hospital associations, was represented by counsel at each of the 14 days of hearings in this matter. The hospital industry failed to rebut this evidence establishing the separate identity of the RN unit regardless of variations among hospitals.

(b) Much the same is true with respect to the skilled maintenance unit. At the rulemaking hearing, the unions presented record evidence with respect to the characteristics of skilled maintenance employees employed in hundreds of hospitals across the nation, varying in size from 38 beds to nearly 2000 beds; located in large metropolitan areas as well as rural settings; ranging from general acute care hospitals to teaching hospitals

as well as facilities concentrating on such specialties as cancer and children's care. IUOE Exhibit 2 (revised), Tr. Chicago II 305-309, Tr. 5651. Evidence was adduced with respect to hospitals whose skilled maintenance employees have been represented in separate units for varying periods of time ranging from years to decades, and where the skilled maintenance unit is one of many units at the facility as well as where it is the only unit. IUOE Exhibit 2 (revised), D.C. Tr. 158, Tr. Chicago II 179, Tr. 5321.

As the NLRB concluded, regardless of such institutional variables, "the evidence . . . shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees." J.A. 147.⁴¹

Thus, regardless of the facility, the empirical evidence established, and the NLRB found, that: (1) the skilled maintenance employees are the only employees performing the distinct function of operating, maintaining, and repairing the facility's physical plant, D.C. Tr. 150-151,

⁴¹ The evidence presented with respect to this issue included testimony from several currently-employed hospital skilled maintenance workers, Statement of Samuel Fowler; Tr. 3445-3454 (Vince Carick), 5352-79 (William Jacquin); testimony from no less than 25 business managers for locals of the Operating Engineers, each of whom reported on the hospital skilled maintenance units that their locals represented, Chi. II Tr. 161-82 (Phil Schloop, Michael Kelly and supporting affidavits), Tr. 3433-84 (Robert Fox, Arthur Viat and supporting affidavits), Tr. 5315-52, 5379-5402 (Michael Hach, Vincent Giblin, Tr. 5412-5413 (Reese Hammond and supporting affidavits); testimony from experienced training personnel, Chi. II Tr. 182-189 (Marvin Schwenn), Tr. 5402-5420 (Reese Hammond), Statement of William Denevi; and expert testimony from Dr. Ray Marshall, Professor of Economics at the University of Texas, Tr. 4006-20, as well as other academics and health care experts, Tr. 4994-4995 (Dr. William H. Wilkinson), Tr. 5425-5427, 5454, 5467-5468 (Dr. Carol O'Cleireacain), Tr. 5480-5481, 5493-5494 (Dr. Fred McKinney), Tr. 5697-5702, 5708-5709, 5720 (Dr. Daniel Cornfield).

156 (Lake), Tr. Chicago II 164 (Schloop), Tr. 3448-3450 (Carrick), 3457-3459, 3466, 3476-3477 (Viat), 4010 (Marshall), 4995 (Wilkinson), 5720 (Cornfield), 5318 (Hach), 5354-5360 (Jacquin), 5382-5383 (Giblin), Reese Hammond Exh. 1, pp. 580-623; (2) skilled maintenance employee are in a separate department under separate supervision with limited and inconsequential contact with other employees, D.C. Tr. 156 (Lake), Tr. Chicago II 178, 212-213 (Kelly), 329 (Comer), Tr. 3117 (Schauer), 3448, 3453-3454 (Carrick), Tr. 3457, 3478 (Viat), 4014 (Marshall), 5002 (Dretchan), 5330, 5342, 5354 (Hach), 5360, 5376 (Jacquin), Hammond Exh. 1, pp. 581-590, Fox Exh. 2 (Pelroy, Bushey), Hammond Exh. 12 (Tighe, Chambers, Scadden); (3) skilled maintenance employees neither perform work outside their function, nor are other employees cross-trained or transferred to perform skilled maintenance work, D.C. Tr. 163-165 (Lake); Tr. Chicago II 204-205 (Schloop), 212, 216-217 (Kelly), Tr. 3541-3542 (Gallagher), 4025-4026 (Houston), 4195 (Sokatch), 4268-4269 (Weinrich), 4740-4741, 4753 (Ryan), 5400 (Giblin), 5427, 5467-5468 (O'Cleireacain), 5481 (McKinney), 5603-5604 (Berliner); (4) the labor markets in which skilled maintenance employees are hired and advance are separate from those of other employees, and their levels of wages, skill, and professional employees, D.C. Tr. 144, 154-155, 490 (Lake); Tr. Chicago II 163, 165, 203-205 (Schloop), 177, 216-217 (Kelly), Tr. 3344-3345 (Corbett), 3436-3437 (Fox), 3459-3460 (Viat), 4010, 4012, 4018-4019 (Marshall), 4739-4741, 4753 (Ryan), 4994 (Wilkinson), 5327, 5344-5345 (Hach), 5363-5364, 5374, 5377 (Jacquin), 5384, 5400 (Giblin), 5404-5405, 5409-5412 (Hammond), 5425-5427 (O'Cleireacain), 5454, 5468, 5493 (McKinney), 5603-5604, 5645 (Berliner), 5697-5702, 5708-5709 (Cornfield); IUOE Exh. 4; Hammond Exh. 1; and (5) the bargaining interests of skilled maintenance employees differ substantially from those of other groups of employees regardless of the size, location or specialty of the fa-

cility, Tr. Chicago II 164-165, 168-169 (Schloop), 175 (Kelly), 209 (Schwein), Tr. 3465-3467 (Viat), 3730, 3734 (Ratner), 4011 (Marshall), 4492-4493 (Willman), 4698-4699, 4729-4730 (Olson), 4785, 4795-4796 (Muehlenkamp), 5187 (Shea), 5388 (Giblin).

As with the RN unit, the evidence establishing these facts regarding the skilled maintenance unit was produced on the record by witnesses subject to full cross examination, and again the AHA failed to rebut any of the foregoing evidence. The AHA's failure in these regards is indicative of the weakness of its claim that the NLRB acted arbitrarily in promulgating the Rule.

4. Perhaps the best evidence of how little there is to the AHA's "diversity" argument comes from the evidence the AHA cites in an attempt to support its contention.

(a) The AHA first faults the Board for "blithely disregard[ing] hundreds of letters submitted by hospitals detailing their size and workforce structure." AHA Br. at 42. But, as the Agency observed, these were mostly form letters, many of which had spaces for hospital administrators to fill in blanks, and one of which was even submitted without the blanks filled in. J.A. 205. To the extent the comments made substantive points the Board, in the preamble to the final rule, summarized the points, J.A. 207-209 (listing 18 points made in the final round of comments) and responded to these points, *e.g.*, J.A. 218-21 (addressing specific comments cited by the AHA Br. at 42-43 n. 24, as having been disregarded).

Of these hundreds of comments, the AHA notes only one, from the Marshalltown Medical & Surgical Center, which purportedly is inconsistent with the groupings found appropriate by the Board. AHA Br. at 42-43 n. 24. The AHA claims that this comment contains evidence that hospitals "have assigned employees to perform duties across the traditional employment categories." *Id.* But

what the comment in fact says is that at Marshalltown Medical and Surgical Center, "security guards also work the switchboard and do maintenance work." And since *NLRA* § 9(b)(3) requires a separate guards unit that comment hardly undermines the groupings contained in the Rule.

(b) The AHA next contends that "the Board had previously found that small or rural hospitals, given their limited resources, often required that employees perform atypical functions." AHA Br. at 44. But the cases the AHA cites to support this proposition, by the AHA's own description, all involve situations in which the lines between professional and non-professional employees (RNs and LPNs, or technicians and technologists) became blurred. See AHA Br. at 44 n.27. Again, however, the professional/non-professional line is one required by *NLRA* § 9(b)(3), and thus the examples the AHA cites do not undermine the Rule.⁴²

(c) Third, the AHA argues that the Board's "assumption[s]" regarding skilled maintenance employees are "untrue at many hospitals where all maintenance workers assist in tasks throughout the hospital, coming in

⁴² Elsewhere in its brief the AHA faults the Board for failing to treat small hospitals differently than large hospitals. See AHA Br. at 40 n.22. The Board found, however, that "[t]he vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals." J.A. 162, citing comments from four unions, 40 employers, and two expert witnesses.

The AHA contends that the Board misunderstood its position. But at the rulemaking hearing, the AHA's witness testified that "[i]f anything there is more integration [of employees] in a larger institution that has product line management than there is in a smaller institution that has the more traditional standard of patient care." D.C. Tr. 37 (Stickler).

contact with service workers, and particularly where complex maintenance work is farmed out to independent contractors." AHA Br. at 44 (citing two disparity-of-interest decisions). But the contracts between skilled maintenance employees and other workers is not a factor that sets some hospitals apart; to the contrary, the Board found that throughout the industry "skilled maintenance employees do perform work throughout the hospitals" and "have contact with just about every other employee in a hospital," but the Board concluded that this "brief, limited, and incidental" contact did not render the skilled maintenance unit inappropriate. J.A. 136. And while it is undoubtedly true that hospitals differ significantly as to their use of outside contractors to do complex repairs, that simply means that there will be variations among hospitals as to the *number* and *types* of craftsmen employed (or whether any are employed), but says nothing about the appropriateness of a separate unit for those skilled maintenance workers who are employed by a hospital.⁴³

(d) Finally, the AHA asserts that "the assumption that business clerical workers invariably differ from and have little contact with other non-professional employees is belied by the findings in numerous cases." AHA Br. at 44-45. But the *facts* as found in those two cases—including the finding of "geographic separation" which the AHA acknowledges, AHA Br. at 45 n.29, essentially *accord* with the Board's findings in the rulemaking regarding business office clericals; those cases simply reflect the application of a different legal test. And in promulgating the Rule the Board specifically stated that in light of its deeper understanding of the business office operation, "we find it unlikely that we would reach the same result" as was reached in *Baker Hospital*, 279 NLRB 308 (1986). See J.A. 159-60.

⁴³ Of course, if a hospital employs five or fewer skilled maintenance employees, the Rule by its terms is inapplicable and a unit determination will be made on a case-specific basis.

In sum, the AHA fails to offer even a single instance in which the findings underlying the Rule are inapplicable, or the groupings established by the Rule inappropriate. *A fortiori*, the AHA fails to carry its burden of establishing that the Rule's generalizations are so off-target as to be arbitrary and capricious.

CONCLUSION

For the foregoing reasons, and those stated in the brief of the National Labor Relations Board, the judgment of the court of appeals should be affirmed.

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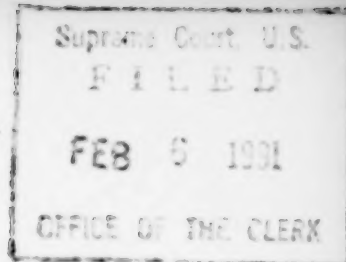
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No. 90-97

IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

**On Writ Of Certiorari To The United States
Court Of Appeals For The Seventh Circuit**

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National Labor Relations Act, 29 U.S.C. § 151

et seq.:

Section 9(b), 29 U.S.C. § 159(b) 3, 4, 5, 6, 12

Section 9(c), 29 U.S.C. § 159(c) 3

LEGISLATIVE HISTORY:

*Legislative History of the National Labor Relations**Act 1935* (Reprint ed. 1985) 1, 4, 6

MISCELLANEOUS:

A. Cox, D. Bok, R. Gorman & M. Finkin, *Labor Law* (11th ed. 1991) 11NLRB, *First Annual Report* (1936) 1, 5, 7NLRB, *Tenth Annual Report* (1945) 5NLRB, *Eleventh Annual Report* (1946) 5NLRB, *Twelfth Annual Report* (1947) 5NLRB, *Thirteenth Annual Report* (1948) 5Taft, "American Hospital Association v. NLRB: Can the NLRB Promulgate Rules Establishing *per se* Appropriate Bargaining Units for Acute Care Hospitals?" 24 *J. Health & Hosp. L.* 1 (1991) 12-13

REPLY BRIEF FOR THE PETITIONER

In our opening brief, we argued that the rule issued by the National Labor Relations Board designating eight specific bargaining units as the only appropriate units for acute-care hospitals violates the requirement of Section 9(b) of the NLRA that the Board determine the appropriate bargaining unit "in each case." Congress—and the Board for over 50 years—have recognized that the question of whether a bargaining unit is appropriate "is obviously one for determination in each individual case" and that "[t]he complexity of modern industry, transportation, and communication, and the numerous and diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case." 1935 *Leg. Hist.* at 2930; NLRB, *First Annual Report* 112 (1936).

Respondents attempt to obscure the narrow, statutory basis of our argument by characterizing it as a broadside attack on the administrative discretion and rulemaking powers of the Board and the authority of the Board to interpret the Act. See Brief for the National Labor Relations Board ("NLRB Br.") 17-20. To the contrary, our argument applies only to that subsection of the Act where Congress included language requiring individual, case-by-case determinations. Moreover, as this Court has frequently held, the notion that courts should defer to an administrative agency's interpretation of its governing statute applies only when the statute is silent or ambiguous, and not when Congress clearly intended a different interpretation.

Respondents would like this Court to believe that we propose a radical departure from the way in which the Board handles representation questions. See NLRB Br. 20. In fact, all we request is that the hospital industry receive the same individualized treatment as all other industries and that the Board determine bargaining-unit questions for hospitals exactly as it has done for all em-

ployers since 1935. As the Unions argued in 1973—and as they remind us in their brief—it is “improper to ‘establish[] different procedures for nonprofit hospitals than for other business establishments.’” Brief for the American Nurses Association, *et al.* (“Union Br.”) 27 (quoting 1973 testimony of AFL-CIO Legislative Director). It is the Board’s effort to treat all hospitals as if they were identical and to dispense with the usual case-by-case method of determining bargaining units that radically departs from both tradition and the requirements of the statute.

I. The Board’s Rule Is Contrary To The Requirement Of Section 9(b) That The Board Determine The Appropriate Unit “In Each Case”

A. Deference To The Board’s Interpretation Of Section 9(b) Is Inappropriate When Congressional Intent Is Ascertainable

Respondents, citing *NLRB v. United Food & Commercial Workers Union*, 484 U.S. 112 (1987), assert that the opinion of the Board majority that Section 9(b) of the Act does not require individual, case-by-case determination of bargaining-unit appropriateness is “rational” and therefore entitled to deference from this Court. NLRB Br. 16, 26 n.22; Union Br. 9. But deference to an administrative interpretation is warranted only “where ‘the statute is silent or ambiguous with respect to the specific issue.’” 484 U.S. at 123. See also *id.* at 134 (Scalia, J., concurring). Respondents ignore the fact that, “[o]n a pure question of statutory construction,” the Court’s

first job is to try to determine congressional intent, using “traditional tools of statutory construction.” If we can do so, then that interpretation must be given effect, and the regulations at issue must be fully consistent with it.

Id. at 123. See also *Dole v. Steelworkers*, 110 S. Ct. 929, 934-938 (1990); *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446-448 (1987); *Chevron U.S.A. Inc. v. Natural Resources*

Defense Council, Inc., 467 U.S. 837, 842-843 & n.9 (1984); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 289 (1974).

Our argument is not that the Board’s rule is wholly irrational or entirely inconsistent with the general principles of the Act. If the statute were silent or ambiguous on the specific issue, the Board’s rule might well be entitled to deference. But the statute is *not* silent or ambiguous on the specific issue involved in this case. As we demonstrated in our opening brief (at 13-25), the “in each case” language of Section 9(b) was clearly intended to require individual, case-by-case determinations of bargaining unit appropriateness and to preclude the adoption of the very kind of rigid rule that the Board has now adopted. In these circumstances, when “traditional tools of statutory construction” reveal a meaning inconsistent with the Board’s regulation, the question of deference never arises.

B. The Language And Legislative History Of Section 9(b) Demonstrate That Individual, Case-By-Case Unit Determination Is Required

The Board’s strained interpretation of Section 9(b) proves both too little and too much. In the Board’s view, “the words ‘in this case’ refer to the proceeding in which the Board is to issue its bargaining unit determinations” (NLRB Br. 16). But if that had been the sole purpose of the language, it would not have been necessary, given the requirement of Section 9(c) that the Board “decide the appropriate unit in individual * * * cases.” NLRB Br. 9.

Even on its own terms, however, the Board’s interpretation of Section 9(b) is defective. Only in the most trivial sense can it be said that the Board’s rule is consistent with the requirement that “the Board render its bargaining unit determinations in each individual representation proceeding” (NLRB Br. 17). To be sure, the Board’s unit determinations will be announced in the context of an “individual representation proceeding” under Section 9(c). But the determinations themselves will be preordained by

the categories imposed by the Board's rule. Thus, contrary to the Board's assertion (NLRB Br. 15-16 n.8), the "dichotomy" between "individual case-by-case determinations of bargaining units" and the determinations imposed in *every* case by the Board's rigid rule is hardly "false." What is false is the Board's preposterous claim (NLRB Br. 29, 20) that its rule will not "deprive acute care hospitals of meaningful consideration of facts *material* to the Board's bargaining unit determinations" and will result in "a decision tailored to the individual case." See Pet. Br. 20.

By the same token, respondents have tried and failed to come up with some legislative history or reasonably contemporaneous interpretation of Section 9(b) to refute the mountain of evidence that the statute requires exactly what the Board over the years has held that it requires: individual, case-by-case consideration of the particular circumstances of each employer. When it added the "in each case" language to the Act, Congress explained that the decision of whether a bargaining unit is appropriate "is obviously one for determination *in each individual case*." 1935 Leg. Hist. at 2930, 2976, 3072 (emphasis added). Congress based its decision on the experience of the earlier New Deal labor boards, which had held that "[t]he question of the proper unit or units must be left for determination according to the circumstances of particular cases as they arise." *Houde Engineering Corp.*, 1 *Decisions of the [First] National Labor Relations Board* 35, 44 (1934).

In accordance with the language and the legislative history of the statute, the Board has consistently acknowledged that Section 9(b) precludes the adoption of rigid rules on the appropriateness of bargaining units. As recently as 1980, in a case involving an acute-care hospital, the Board held that the adoption of a conclusive presumption that a unit of registered nurses would be appropriate in every hospital would violate the Act. "Such a *per se* approach to unit determination is inconsistent with the Board's Section 9(b) responsibility to decide 'in each

case' whether the requested unit is appropriate." *Newton-Wellesley Hosp.*, 250 NLRB 409, 411 (1980).

In its first annual report, the Board recognized that Congress was wise to require individual consideration of unit appropriateness because the many differences between employers and unions "preclude the application of rigid rules to determine the unit appropriate in each case." NLRB, *First Annual Report* 112 (1936). And, as the Board now admits (NLRB Br. 24 n.19), in another early (1942) annual report it acknowledged that it had a "'duty under the Act' to 'decide[] each case on the basis of all the facts and circumstances involved.'" In addition, in the first annual report issued after the Taft-Hartley Act was passed, the Board again stressed that it would "decid[e] each case on its own facts, *as it must do*." NLRB, *Thirteenth Annual Report* 36 (1948) (emphasis added). See also the Board's *Tenth Annual Report* 26 (1945) ("The issue of appropriateness * * * must be resolved in accordance with the facts in each case"); *Eleventh Annual Report* 23-24 (1946) ("the particular facts of each case are determinative of" the issue of bargaining unit appropriateness); and *Twelfth Annual Report* 18 (1947) ("each case must be decided on its own particular facts").

The Board's repeated acknowledgment that it *must* decide each bargaining unit case "on its own facts" and "on the basis of all the facts and circumstances involved" is powerful evidence of the proper meaning of the statute. Indeed, the Board's "failure for over [50] years to exercise the power it now claims under [Section 9(b)] strongly suggests that it [has never] read the statute as granting such power." *BankAmerica Corp. v. United States*, 462 U.S. 122, 131 (1983). See also *FPC v. Panhandle Eastern Pipe Line Co.*, 337 U.S. 498, 513 (1949); *FTC v. Bunte Bros.*, 312 U.S. 349, 351-352 (1941).

Against all of this evidence, the Board (Br. 22) can muster only one inconclusive snippet of legislative history

that is of questionable relevance and that supports our position more than it does that of the Board. John P. Frey, President of the Metal Trades Department of the AFL, testified that he “t[ook] it for granted” (under the bill as it stood *before* the “in each case” language was added) that, “when a specific case comes to the Board, in the individual case the Board will decide which shall be the unit of representation.” *1935 Leg. Hist.* at 1583. Mr. Frey then proposed his own amendment, which was somewhat different from the “in each case” language.

Mr. Frey’s testimony came a full week after Secretary Perkins had offered her amendment adding the “in each case” requirement. See *1935 Leg. Hist.* at 1433, 1445, 1573 & 1583. We fail to see how this ambiguous testimony supports the Board’s position. Similarly, we fail to understand how the testimony of a witness who proposed a different amendment that was never seriously considered can cast any light on the meaning of an earlier amendment that Congress in fact adopted. The Board has offered very little indeed to support its reading of Section 9(b).

C. Under The Rule, The Board Will Not Continue To Provide Meaningful, Case-By-Case Unit Determinations In The Hospital Industry

Apparently recognizing—as it has done so often in the past—that Section 9(b) *does* require individual, case-by-case determinations of bargaining unit appropriateness, the Board contends that it will continue to make such determinations under the rule and that the rule does nothing more than “narrow and define the issues.” NLRB Br. 22-26. To argue that any sort of meaningful consideration will be given under the rule to the individual circumstances of any hospital is to engage in a charade.

As we demonstrated above and in our opening brief, Section 9(b) requires case-by-case unit determination in order to take into account the particular circumstances of

each employer and group of employees. As the Board and this Court have recognized, “[t]he complexity of modern industry * * * and [the] diverse forms which organization among employees has taken, preclude the application of rigid rules to determine the unit appropriate in each case” and require careful consideration of the facts of each case. NLRB, *First Annual Report* 112. See also *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

The Board’s promise that it will continue to determine the appropriate unit based upon the facts of each case is transparently an empty one. Although the Board might still conduct a hearing in every contested case, by its own admission that hearing will be a mere formality in which the Board will mechanically apply the bargaining unit rule and will not consider the individual circumstances of the hospital involved “except in extraordinary circumstances.” Final Rule, J.A. 259. Even under the “extraordinary circumstances” exception, the Board will not consider the hospital’s size, staffing patterns, functional integration or increased specialization of employees, the variety of services offered by the hospital, or any of the other differences among hospitals that were “revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field.” NPR II, J.A. 189-190. In short, the Board has expressly promised that it will give *no* meaningful consideration to any of the known differences among hospitals. The Board’s argument that it will continue to determine the appropriate unit “in each case” is frivolous.¹

¹ The Unions argue that the rule would not apply in circumstances where it would be “accidental or unjust.” Br. 21. See also NLRB Br. 30 n.28. But any fair reading of the Board’s rulemaking confirms that the Board will not even consider a wide range of factors that are considered critical in every other industry. NPR II, J.A. 186-190.

D. The Board's Rule Is Not Analogous To The Bargaining Unit "Rules" It Has Announced For Other Industries

Respondents' argument (NLRB Br. 23-26; Union Br. 16-20) that the Board's rule is much the same as the "rules" it has announced for other industries is equally unavailing. The Board's acknowledgment (Br. 26) that "[t]he present regulation leaves less leeway for exceptions than many of the rules previously established" is a classic understatement. In *no* other industry has the Board established a rule—by rulemaking or adjudication—that particular units, and only those units, will be regarded as appropriate in every case. The most it has done is to establish general guidelines or rebuttable presumptions that certain units will ordinarily be considered appropriate absent contrary evidence. But as the Board concedes (Br. 24-25), those presumptions apply only "in the absence of persuasive reasons to the contrary."²

Accordingly, as to every other "rule" the Board and the Unions cite, the parties are given a full opportunity to demonstrate that particular circumstances warrant a different result. See, *e.g.*, *Texas Electric Service Co.*, 261 NLRB 1455 (1982), and *Tidewater Telephone Co.*, 181 NLRB 867 (1970) (under the particular facts involved, the Board declines to follow the *Baltimore Gas & Electric* "rule" that systemwide units are appropriate in the utility industry); *Orkin Exterminating Co.*, 258 NLRB 773 (1981) (the Board finds that the presumption that each separate facility in a multifacility operation should be in a separate unit has been rebutted by the facts of the particular case); *ITT Continental Baking Co.*, 231 NLRB 326 (1977), and

² The Unions' suggestion (Br. 10) that our argument "would require overturning countless NLRB decisions" establishing rebuttable presumptions that certain bargaining units will ordinarily be regarded as appropriate is nonsensical. *None* of the rules that the Board has announced for other industries is even remotely analogous to the rule at issue in this case.

Petrie Stores Corp., 212 NLRB 130 (1974) (the Board finds that the presumption of separate units for each store in the retail industry has been rebutted); *Journal Times Co.*, 209 NLRB 745 (1974) (Board declines to follow the rule of *Garden Island Publishing* that separate craft units are ordinarily appropriate in the newspaper industry, holding that an unusual degree of work integration warrants a more comprehensive unit); *Farmers Insurance Group*, 187 NLRB 844 (1971) (the Board holds that the presumption in favor of separate units for each district office in the insurance industry has been rebutted).³ The approach the Board follows in these other industries is a far cry from what the Board proposes to do in the hospital industry, where it will not allow an employer even to offer evidence that the circumstances of the particular hospital warrant a departure from the general rule.⁴

³ The Board (Br. 26 n.21) cites *Esco Corp.*, 298 NLRB No. 120 (June 20, 1990), as another case in which it has announced a "rule[] of decision" governing bargaining unit determinations that is analogous to the rule at issue in this case. In actuality, the Board's discussion of how it applies the presumption involved in that case (slip op. 8) demonstrates how different such presumptions are from the rigid hospital-industry rule:

Unit Scope: A single plant or store unit location is presumptively appropriate unless it has been so effectively merged into a more comprehensive unit, or is so functionally integrated, that it has lost its separate identity. *Dixie Belle Mills*, 139 NLRB 629, 631 (1962). To determine if the presumption has been rebutted, the Board looks to such factors as central control over daily operations and labor relations, including the extent of local autonomy; similarity of the employee skills, functions, and working conditions; degree of employee interchange; distance between locations; and bargaining history, if any. See *Dixie Belle Mills*, *supra*; *Gray Drug Stores*, 197 NLRB 924, 925 (1972); *Sol's*, 272 NLRB 621 (1984); and *Bowie Hall Trucking*, 290 NLRB No. 8 (July 29, 1988).

⁴ The Board's responsibility to consider the facts of each case is emphasized in one of the principal cases it misguidedly relies on for the proposition that it has adopted similar rules in other industries. In *E.H. Koester Bakery*, 136 NLRB 1006 (1962), the Board held that "the complexity of modern industry, with its many vari-

(Footnote continued on following page)

Ignoring the flexible and rebuttable nature of the "rules" the Board has announced in other industries, the Unions advance the rather bizarre argument that "the policies of the Act demand that unit determinations be made across an industry." Union Br. 16-19. Neither of the reasons they give for this argument can bear scrutiny. To begin with, the Unions' claim that the electoral system of the NLRA and the administrative process of the Board would collapse absent such rules cannot be taken seriously, because they have *not* collapsed even though the Board has not established rigid bargaining unit rules for any other industry. In fact, the system works quite well and the ability of employees to decide whether to self-organize for collective bargaining has been *enhanced* by the fact that organization can take place in a bargaining unit appropriate for the particular employer and group of employees.⁵

The Unions also argue that the Act *demands* uniform bargaining units across each industry in order to allow particular unions to organize entire industries, and thus

⁴ *continued*

ables, precludes, for the most part, the application of fixed rules for the unit placement of truckdrivers." 136 NLRB at 1010. Application of an "automatic rule" that drivers would be included in a larger unit would amount to an improper "refusal to consider [the bargaining unit issue] on its merits." *Id.* at 1011.

⁵ Respondents seem to believe that their position is somehow bolstered by the fact that the Act has long been interpreted to require only that the Board determine whether a given unit is "an appropriate unit, not the most appropriate unit." NLRB Br. 29. See also Union Br. 13. But that longstanding interpretation reflects the fact that designating particular units as the *most* appropriate (and therefore the *only* appropriate) units would be unduly restrictive of organizational freedom. See, e.g., *Morand Bros. Beverage Co.*, 91 NLRB 409, 417-419 (1950), enforced, 190 F.2d 576 (7th Cir. 1951); *Garden State Hosiery Co.*, 74 NLRB 318, 324 (1947). In finding conclusively that the eight units listed in the rule are the *only* appropriate units in the hospital industry, the Board has eliminated the very flexibility that Congress intended it to have in determining "in each case" whether the particular unit requested is *an* appropriate unit.

to eliminate all wage competition between employers. Union Br. 18-19. That argument harkens back to the days before the Taft-Hartley Act was passed and before the national labor policy became one of neutrality on the issue of whether employees should join unions and engage in collective bargaining. See A. Cox, D. Bok, R. Gorman & M. Finkin, *Labor Law* 95 (11th ed. 1991). It is no longer national labor policy to encourage collective bargaining, and it is certainly not national labor policy to encourage unions to eliminate all wage competition in every industry by facilitating the organization of all employers in an industry by the same unions. It may be true that the ability of particular unions to organize all hospitals, to eliminate all wage differentials, and to force compliance with their other demands would be greatly increased by a rule that the same units are appropriate in every facility. But that is certainly not necessary, or even desirable, to further national labor policy.⁶

II. The Board's Rule Is Contrary To The Congressional Admonition

As we explained in our opening brief (at 26-38), the congressional admonition reflects Congress's understanding that, once the Act was applied to non-profit hospitals, the Board would continue to make bargaining unit determinations on a case-by-case basis, taking into account all of the factors considered in other industries, and would be particularly sensitive to the dangers of unit proliferation. The Board and the Unions continue to argue that in agreeing upon the congressional admonition and in passing the 1974 amendments, "Congressional and industry concern with

⁶ The Board—relying primarily on *Heckler v. Campbell*, 461 U.S. 458 (1983)—also argues that its interpretation of the "in each case" language is consistent with the way this Court has interpreted "analogous statutes." NLRB Br. 27-28. We demonstrated in our opening brief (at 21-23) that neither *Campbell* nor the other cases cited by the Board supports the Board's position.

proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately." NLRB Br. 38, quoting J.A. 191. See also Union Br. 23-25. We find it significant that neither the Board nor the Unions can find any support for their argument in the authoritative committee reports accompanying the 1974 Act, but instead rely upon isolated statements of partisan witnesses and a few legislators.

The Board (half-heartedly) and the Unions argue that the admonition is completely irrelevant. NLRB Br. 31; Union Br. 31-36. But as the court of appeals pointed out, the 1974 amendments resulted in the application of the entire Act to the health-care industry. Thus, in "changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words." Pet. App. 11a-12a. It certainly is relevant to look at what Congress said at the time it enacted the legislation applying the Act to this industry. And the congressional admonition is the strongest kind of legislative history imaginable—a statement, obviously well thought out in advance, contained in both committee reports. Accordingly, it is not surprising that the Board, in its prior hospital bargaining unit cases, has regarded the admonition as highly significant. See, e.g., *St. Francis Hosp.*, 271 NLRB 948, 951 & n.17 (1984) ("*St. Francis II*"), remanded, 814 F.2d 697 (D.C. Cir. 1987) (specifically rejecting the argument that the admonition should be disregarded in light of the fact that the earlier bill limiting the number of units was not passed); *Newton-Wellesley Hosp.*, 250 NLRB at 412; *Mercy Hosp. of Sacramento, Inc.*, 217 NLRB 765, 766-767 (1975).

Little purpose would be served by responding to the Unions' one-sided account of the 1974 legislative history, particularly since the principal sponsor of the Act—Senator Robert Taft, Jr.—has now written an article fully and fairly examining that history. Taft, "*American Hospital Asso-*

ciation v. NLRB: Can the NLRB Promulgate Rules Establishing *per se* Appropriate Bargaining Units for Acute Care Hospitals?" 24 *J. Health & Hosp. L.* 1 (1991).⁷ We agree with Senator Taft (*id.* at 2) that "the post-enactment statements of legislators cannot and should not serve as a basis for deriving legislative intent," but we find his analysis of the pre-enactment history to be cogent and informative.

III. The Board's Rule Is Arbitrary And Capricious

In our opening brief (at 38-47), we argued that the Board's rule is arbitrary and capricious in that it ignores critical differences among acute-care hospitals, including differences in size, location, operation, and workforce organization. The court of appeals dismissed this challenge without any discussion of the evidence in the record, stating only that the Board's reasoning was "plausible" and "not unreasonable." Pet. App. 15a, 16a. Perhaps conceding the weakness of the court of appeals' discussion, the Board makes virtually no attempt to defend the rule on the grounds relied on by the court below. Instead, respondents advance a bevy of other arguments, none of which, however, supports the Board's rule.⁸

To begin with, contrary to the Board's mischaracterization (NLRB Br. 41), we do not contend that the *per se* bargaining-unit rule is arbitrary and capricious simply "because it contradicts a footnote in" *St. Francis II*. The *per se*

⁷ We have lodged copies of Senator Taft's article with the Clerk of the Court.

⁸ The Unions engage in wishful thinking when they assert (Br. 5) that AHA "does not challenge either the Board's finding that each of [the eight] units represents a 'natural grouping' with 'truly distinctive * * * concerns' or the Board's finding that these units are sufficiently broad and functionally distinct as not to beget whipsawing or labor unrest." Our argument throughout is that by pretending that all hospitals are alike, the Board has precluded any meaningful consideration of those important concerns in individual cases.

rule—and its underlying premise that all acute-care hospitals are “virtually identical” (e.g., NPR I, J.A. 21)—is irreconcilable not just with *St. Francis II*, but with the overwhelming evidence relied on by the Board and the courts of appeals in numerous decisions before and after *St. Francis II* that the substantial differences among hospitals required that the determination of appropriate bargaining units be done on a case-by-case basis. As the Board stated in *Otis Hosp. Inc.*, 219 NLRB 164, 165 (1975):

[N]ot all health care institutions may be exactly alike. * * * Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself.

See also, e.g., *NLRB v. St. Francis Hosp. of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979) (registered-nurses unit appropriate in one facility may not be appropriate in another); *Newton-Wellesley Hosp.*, 250 NLRB at 415 (separate RN units “are [not] always appropriate,” since “some aspects are sure to vary” among hospitals); *NLRB v. Frederick Memorial Hosp., Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (rejecting *per se* RN unit because a separate unit “might not be appropriate in other hospitals”).⁹

Indeed, as we showed in our opening brief (at 14-19, 20), the Board’s adoption of a *per se* rule here runs counter to its approach to bargaining unit determinations in every other sector of the economy. The hospital indus-

⁹ As the Board observes (NLRB Br. 41), *St. Francis II* predicted that case-by-case adjudication itself over time would “illustrate which units are typically appropriate.” 271 NLRB at 953 n.39. But determining that some units are “typically” appropriate is a far cry from declaring that those units are *always* appropriate, without any regard to individual circumstances however compelling.

try is the only one that the Board has treated with a blanket rule. This treatment is especially arbitrary given that the hospital industry is currently among the most diverse and dynamic in the country. It is also especially anomalous and unjustified because the congressional admonition singles out health care institutions for precisely the *opposite* treatment—requiring a sensitive analysis of whether the requested bargaining unit will lead to a proliferation of units at the particular hospital.

The Board concedes (NLRB Br. 42) that in individual cases, it and the courts have previously rejected several of the separate units that it now deems *per se* appropriate. See Pet. Br. 43-45; see also *St. Francis Hosp.*, 286 NLRB 1305 (1987) (“*St. Francis III*”) (maintenance unit); *St. Vincent Hosp. & Health Center*, 285 NLRB 365 (1987) (RN unit). In other words, under the close inspection of an adjudication, numerous hospitals prove to have features “inconsistent with what the Board now perceives to be industry practice as a whole”—which “in itself, tend[s] to refute any claim that the industry is uniform.” Comment S-905, *Humana Inc.*, at 2. We cited a few examples in Pet. Br. 43-45, and will add a few more here.

The rulemaking generalized that maintenance workers have different terms and conditions of employment from service workers, do not interchange positions with service workers, are separately supervised, and have only “brief, limited, and incidental” contact with other employees. NPR II, J.A. 132-137. At some hospitals, however, maintenance workers share basic terms and conditions with other employees (*St. Francis III*, 286 NLRB at 1307; *NLRB v. West Suburban Hosp.*, 570 F.2d 213, 216 (7th Cir. 1978)); spend a “large percentage,” up to 75 or 80% of their time working with other employees (*Jewish Hosp. Ass’n*, 223 NLRB 614, 616 (1976); *NLRB v. West Suburban Hosp.*, 570 F.2d at 216); “transfer to service jobs and vice versa” (*Jewish Hosp. Ass’n*, 223 NLRB at 616; *St. Francis III*, 286 NLRB at 1307); and

share common supervision with other employees (*Jewish Hosp. Ass'n*, 223 NLRB at 616). Likewise, contrary to the generalizations of the rulemaking regarding the separateness of registered nurses (NPR II, J.A. 92-102), a hospital with a "multidisciplinary team approach" has been found to have "substantial interaction" between RNs and other professionals, such that an RN will have "more contact with" other professionals in her specialty area "than [with] nurses outside her specialty." *Presbyterian/St. Luke's Med. Ctr. v. NLRB*, 653 F.2d 450, 456 (10th Cir. 1981), cert. dismissed, 459 U.S. 1025 (1982).¹⁰

The Board claims that "the information obtained during the rulemaking * * * cast doubt on" its previous findings of diversity and justified treating all hospitals as if they were alike. NLRB Br. 43; see also NPR II, J.A. 115 n.22, 146-147, 159-160. But this argument is disingenuous. The Board made its decision to treat all hospitals alike *before* it received any information from the rulemaking process. See NPR I, J.A. 12-14; Transcript of NLRB Meeting of May 15, 1987, RM-2-A-1 at 18, 29 (reproduced in the Court of Appeals Supplemental Appendix at 348-349 and in our opening brief at 41-42 n.23). The Board used information received in the rulemaking—and decided what information to accept and what to disregard—*after* it had already determined to find that all hospitals were alike. The Board's "finding" was not based on information obtained during the rulemaking, and it was certainly not based on

¹⁰ Similarly, while the rulemaking generalized that technical employees constitute a "separate and distinct" group (NPR II, J.A. 123-129), the Board has concluded that a combined unit of technical, service, and maintenance employees would be appropriate at a small hospital because the groups "work in close association" and "share common supervision" and "integrated job functions." *Vicksburg Hosp., Inc. v. NLRB*, 653 F.2d 1070, 1074-1075 (5th Cir. 1981) (granting enforcement).

the diametrically opposite findings it had made in prior adjudications.¹¹

In the end, respondents acknowledge the many differences among hospitals—as indeed they must—but argue that this diversity is not "sufficiently significant to preclude uniform treatment of * * * appropriate bargaining units." Union Br. 38-39 (quoting NPR II, J.A. 57-58). That argument cannot be squared with the evidence adduced in the rulemaking. Extensive evidence in the record showed that many hospitals organize some or all of their workforce not along the traditional occupational lines enshrined in the rule, but instead by integrating employees in "teams" or "product lines" according to the kind of treatment such as radiology, cardiology, or oncology.¹² The

¹¹ The Board tries to explain away the contradictions in its previous cases by claiming that they stem from the "doctrinal approach" they employed, i.e., the "disparity of interests" analysis of *St. Francis II*. NLRB Br. 43. But the contradictions in the Board's findings are attributable not to differing doctrinal frameworks, but rather to the circumstances of individual hospitals. Several of the cases that contradict the Board's rulemaking findings were analyzed under standards more liberal (in allowing separate units) than "disparity of interests." See, e.g., *Jewish Hosp. Ass'n*, 223 NLRB at 616-617 (maintenance unit rejected under "community of interest" standard); *NLRB v. West Suburban Hosp.*, 570 F.2d at 216; *Vicksburg Hosp., Inc. v. NLRB*, 653 F.2d at 1074-1075.

¹² See, e.g., Comment 288, Children's Medical Center (Dayton, Ohio) (hospital reorganized on "product line" approach with extensive integration across functions); Comment 248, Cedars-Sinai Medical Center (RNs participate in teams with other licensed professionals); Comment 259, Missouri Hospital Association (state study showed substantial percentage of Missouri RNs perform non-traditional functions); Comment 139, South Baltimore General Hospital (RNs share greater common interests with social workers in same department than with RNs in other departments); Comment 142, St. Anthony's Health Corporation (RNs work in 10 different departments); Comment S-1086, Beth Israel Hospital; Comment S-1279, Freeman Hospital; Comment S-1081, Wausau Hospital Center; Comment S-1375, Greater Cincinnati Hospital Council; Comment S-1082, Main Line Health, Inc.; Thompson, Chi II 14-17; Mixon, Chi II 274-275; Gallagher, 3543, 3545; Graybill, 4186 (separate RN unit could "significantly" damage "interplay" within team).

(Footnote continued on following page)

Board nevertheless resolved to apply its rigid occupation-based units to such hospitals as well, in large part because it found that they constituted a "minority" or "fewer than half" of acute-care hospitals and that where teams are used "a majority of employees do not participate on such teams." NPR II, J.A. 73. The evidence clearly showed that the team approach—even if not the majority form of organization—is sufficiently widespread to make *per se* treatment unwarranted. But the Board, in this and in other instances, arbitrarily ignored extensive evidence of diversity and cavalierly "found" that such differences among hospitals were "not typical."

Moreover, in arguing that additional bargaining units will not cause the problems Congress envisioned, the Board continues to ignore the fact that the effects of proliferation to date have not been severe because the courts have heeded the congressional admonition and have blocked attempts to establish numerous fragmented bargaining units. The Board erroneously assumes that the tolerably low level of unit proliferation that existed when the number of bargaining units was strictly controlled will continue even after those controls are suddenly removed, and that the absence of strikes and other labor unrest during the period when proliferation was prevented somehow proves that proliferation will not cause those problems. But even the court of appeals reached the commonsense conclusion

¹² continued

The evidence also showed that, for somewhat different reasons, cross-training and integration of functions are common at small and rural hospitals. See, *e.g.*, Comment S-1305, St. Joseph Hospital (most employees at small hospitals are "cross-trained in order to assure around-the-clock coverage"); Comment S-1673, Grayson County Hospital (because of low Medicare reimbursement and "critical" shortage of health professionals in rural areas, "many employees within a [small] hospital hold multiple job responsibilities"); Houston, 4043. [In citing to the transcripts of the various hearings on the rule, we have adopted the citation form used by the Board in the *Federal Register*. See J.A. 42-43. "Chi II", for example, is used to refer to the second Chicago hearing.]

that "[t]he more units there are," the more "work stoppages will be likel[y], because there will be more separate decisionmaking centers each of which can call a strike." Pet. App. 3a.

Finally, the Board (NLRB Br. 48 n.48) defends its steadfast refusal to respond to the disproportionate effect such increased burdens would have on some hospitals, particularly small and rural ones. But none of its justifications can withstand analysis. The Board's argument that Congress, in enacting the 1974 amendments, implicitly recognized and accepted the costs of collective bargaining (*ibid.* (quoting Final Rule, J.A. 220)) disregards the fact that Congress sought to *minimize* those costs in this particular industry by directing the Board to avoid a proliferation of units. It is undeniable that, as the Board itself recognized, the "Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services" makes it highly "relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions." NPR II, J.A. 84.

Yet despite this professed concern to preserve the uninterrupted provision of health care services, the Board expressly dismissed "the financial condition of rural or small hospitals" in particular as "[ir]relevant to a determination of appropriate bargaining units." Final Rule, J.A. 229-230 n.3. In so doing, the Board completely ignored the array of testimony concerning the already precarious financial state of many hospitals, the number of closings that could result from substantial increases in costs, and the devastating effect that closings could have on the availability of health care services, particularly in rural areas where one small hospital "may be the sole community provider." Comment S-1524, Falmouth Hospital.¹³

¹³ See, *e.g.*, Comment S-764, Memorial Hospital ("all small, rural hospitals are severely hard pressed"); Comment S-1170, Baptist (Footnote continued on following page)

The Board seems to believe that its regulation should be upheld simply because it is the product of a lengthy, good-faith effort to establish uniform bargaining units for the hospital industry. But neither the length of nor the motivation for that effort can overcome the Board's failure to comply with the statute and to take account of the voluminous evidence of the many relevant differences among acute-care hospitals. Congress required case-by-case determination of unit appropriateness because it recognized that the complexity of modern industry precluded the application of rigid rules in this area. That is as true for the enormously complex hospital industry as it is for any other industry.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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¹³ continued

Health System of East Tennessee (three small hospitals closed in 1988 alone in Tennessee); Comment S-1601, Faxton Hospital (two hospitals in local area already "near the brink of closure"); Comment S-1307, United Hospital Center ("[i]n West Virginia alone, two hospitals have closed [in 1988] and other small rural hospitals are having financial difficulties"); Comment S-567, Catholic Health Corporation ("70% of the nation's hospitals under 100 beds lost money on inpatient care services" in 1987); Comment S-1257, Androscoggin Valley Hospital (rule "will accelerate the rate of closures among rural hospitals"); Comment S-1300, Bowie Memorial Hospital (detailed description of financial pressures on small and rural hospitals).

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Petitioner

v.

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Respondents

On Petition For A Writ Of Certiorari To The United
States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF THE
MARYLAND HOSPITAL ASSOCIATION, INC.

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AMICUS CURIAE BRIEF OF THE
MARYLAND HOSPITAL ASSOCIATION, INC.

I. INTEREST OF THE AMICUS CURIAE

The Maryland Hospital Association, Inc. submits its brief as *amicus curiae* in support of the Petitioner, the American Hospital Association.¹ The Maryland Hospital Association, Inc. ("MHA") is a private non-profit membership organization which has as its primary focus assistance to its member institutions in providing efficient high quality health care in Maryland. The MHA serves as a forum for communication and cooperation among health care providers in Maryland.

¹ All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

The MHA has fifty-three acute care-hospital members representing all the acute care hospitals located in the State of Maryland. App., *infra*, 5a-9a. Its members include large metropolitan hospitals and small rural hospitals. The complexity of services offered in each hospital also varies. Some hospitals are community hospitals providing general care, while others provide tertiary level care in a number of specialty areas. Some of the acute care hospital members of the MHA have psychiatric or mental health units in their facilities while others combine acute care with long-term rehabilitative care.

The largest acute care hospital member of the MHA is The Johns Hopkins Hospital ("Johns Hopkins") located in Baltimore, Maryland, with over 6,000 employees and 1,036 beds. Equally representative of the membership of the MHA, however, is Kent & Queen Anne's Hospital, a small rural hospital in Chestertown, Maryland, with approximately 300 employees and 64 beds. All acute care hospital members of the MHA are subject to the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry ("Final Rule" or the "Rule"). 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30 (1989). Thus, all acute care hospital members of the MHA have a vital interest in the American Hospital Association's challenge to the Final Rule promulgated by the NLRB.

Eleven of the private acute care hospital members of the MHA have employees who are represented by unions. App., *infra*, 10a-12a. These hospitals have experienced the substantial costs associated with negotiating and administering collective bargaining agreements with unions. Four acute care hospital members of the MHA are currently involved in representation proceedings before the Board. On March 10, 1989, the Maryland Nurses Association ("MNA") filed a petition with the NLRB, designated Case No. 5-RC-13206, seeking to represent a unit of approximately 600 registered nurses at Greater Baltimore Medical Center ("GBMC"). The hospital has proposed, as an alternative bargaining unit, an all professional unit which would include numerous other allied health professionals at the hospital. Although a hearing was begun on the issue of the appropriate bargaining unit at GBMC, a ruling on this issue was put on hold by the injunction issued in this case by the United States District Court for the Northern District of Illinois. The United States Court of Appeals for the Seventh Circuit vacated the injunction against enforcement of the Board's Final Rule

on April 11, 1990. The American Hospital Association gained a stay of the court of appeals' order pending this Court's ruling on the petition for a writ of certiorari. The writ of certiorari was granted on October 9, 1990.

A representation proceeding between Peninsula General Hospital Medical Center ("Peninsula General") and the MNA has also been curtailed by the injunction issued by the district court in this case. The MNA seeks to represent a unit of all technical employees at Peninsula General. The hospital, however, seeks to have the NLRB certify a broader unit of all nonprofessional employees. No decision has been issued on this petition, designated Case No. 5-RC-13355 by the NLRB.²

If the decision of the Seventh Circuit is not reversed, however, it is expected that Region 5 of the NLRB will move quickly to apply the Board's Final Rule to the petitions filed at GBMC and Peninsula General. It is expected that the Region will certify the proposed unit of registered nurses as an appropriate bargaining unit at GBMC without considering the special circumstances of employment at the hospital. Similarly, the Region will also approve the proposed unit of technical employees at Peninsula General without considering whether an all nonprofessional unit is the appropriate bargaining unit for Peninsula General employees. If the Seventh Circuit's decision is not reversed, both GBMC and Peninsula General will be precluded from exploring the appropriateness of alternative bargaining units in response to the petitions filed by the MNA.

Those hospitals which have been touched by union organizing or which face application of the Board's Final Rule to pending representation proceedings have relevant information to bring to bear on the question of the validity of a *per se* bargaining unit rule which would impose as many as eight bargaining units on health care

² The other two hospitals involved in proceedings before the Board are Prince George's Hospital Center and Greater Laurel-Beltsville Hospital. District 1199E-SEIU has petitioned to represent technical employees in both hospitals. The petitioned-for unit has been treated as a residual unit by the Board because other technical employees at the hospitals are part of a service and maintenance unit represented by Local No. 63, International Brotherhood of Firemen and Oilers. See discussion, pp. 22-23, *infra*.

workplaces without affording hospitals any opportunity to be heard on the issue of the appropriateness of such units.

The Board's Final Rule ignores the differences between acute care hospitals in Maryland, differences which, in any particular case, make application of the Rule an arbitrary and capricious imposition on the rights of member hospitals of the MHA to deal with their employees over wages, hours and working conditions. The Board's Final Rule also ignores significant trends within acute care hospitals in Maryland including the development of integrated systems for delivery of health care to patients. The Rule fails to give recognition to the extensive interaction between registered nurses and other allied health professionals which is a natural outgrowth of these multidisciplinary approaches to patient care. The Board's Final Rule will only lead to increased disruption within Maryland hospitals and an increase in costs for acute care hospitals already struggling to meet budgetary constraints. The MHA is thus vitally interested in the issues presented by this case and it believes it can illuminate the disruption and associated costs that will be imposed on its acute care hospital members if the Seventh Circuit's decision vacating the injunction against the Rule is allowed to stand.

II. SUMMARY OF THE ARGUMENT

This case raises the issue of the NLRB's authority to promulgate and apply a rule mandating that only eight bargaining units are appropriate within acute care hospitals regardless of their size, location or differences in their operations. The MHA contends that the Board's Final Rule and its *per se* application to all representation petitions involving acute care hospitals is contrary to Section 9(b) of the National Labor Relations Act (the "Act") which requires the Board to decide appropriate bargaining units "in each case". 29 U.S.C. § 159(b). Further, the Final Rule is in conflict with the congressional admonition against proliferation contained in the legislative history of the Health Care Amendments Act of 1974.

The Board's Final Rule provides for eight bargaining units within acute care hospitals. The Rule makes clear that the eight appropriate units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units mandated by the Rule include: "(1) all registered nurses; (2) all

physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30.

The Rule contains an "extraordinary circumstances" exception which may allow petitions involving bargaining units which are not in substantial accordance with the provisions of the Rule. See Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33,932-33 (1988). The Board's "extraordinary circumstances" exception is extremely narrow, however. The Board has stated that it will not consider additional evidence or arguments that a particular hospital varied from the norm, even if the variation is "highly unusual". *Id.* at 33,932. Hospitals bear a "heavy burden" to demonstrate that extraordinary circumstances exist which make application of the Rule inappropriate. *Id.* at 33,933. In particular, the Board has stated that "increased functional integration of and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of 'team' care and cross-training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33,932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. *Id.*

The Board's Final Rule is thus arbitrary and capricious in that its application would ignore the special circumstances of employment within Maryland acute care hospitals and threatens to disrupt the delivery of quality health care at Maryland institutions. Acute care hospital members of the MHA will not have a meaningful opportunity to argue the appropriateness of alternative bargaining units in response to future representation petitions. The Rule is equivalent to an irrebuttable presumption and therefore it is not consistent with the "in each case" requirement of Section 9(b). The harm visited by the Board's Final Rule on acute care hospitals within Maryland can only be avoided by reversal of the Seventh Circuit's decision and reinstatement of the district court's permanent injunction prohibiting implementation of the Rule.

III. ARGUMENT

For over thirteen years, the NLRB determined the appropriateness of bargaining units in acute care hospitals on a case by case basis. In 1987, however, the Board decided to begin rulemaking proceedings to create a uniform rule for determining appropriate bargaining units in the health care industry. On April 21, 1989, the Board issued its Final Rule for determining the appropriateness of bargaining units in acute care hospitals. Instead of rebuttable guidelines for determining bargaining units, the Rule that was created was rigid and inflexible, mandating that only eight specific bargaining units are appropriate for acute care hospitals.

The Petitioner, the American Hospital Association, challenged the Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court issued a permanent injunction barring the enforcement of the Board's Final Rule. *American Hosp. Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule was in conflict with the congressional admonition to give due consideration to preventing proliferation of bargaining units in the health care industry. The court said:

A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

718 F. Supp. at 716.

Respondents appealed the district court's decision to the Seventh Circuit Court of Appeals. In *American Hosp. Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed the decision of the district court and vacated the injunction. The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case by case determination of bargaining units. The court also held that the Rule was not precluded by the congressional admonition against proliferation of bargaining units in the health care field.

Finally, the court of appeals rejected the American Hospital Association's argument that the Final Rule was arbitrary and capricious because it failed to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 659.

The MHA supports the argument of Petitioner in this case that the Board's Final Rule is contrary to Section 9(b) of the Act, is in conflict with the congressional admonition against proliferation of bargaining units in the health care industry, and is arbitrary and capricious. As will be demonstrated below, the Board's Final Rule ignores significant differences among acute care hospitals in Maryland and requires the creation of arbitrary bargaining units in every health care workplace without providing each health care employer the opportunity to demonstrate that the special conditions of employment at its facility merit deviation from the Board's mandated bargaining units.

A. The Plain Language Of The Act Requires A Bargaining Unit Determination In Each Case

Section 9(b) of the National Labor Relations Act provides in pertinent part:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, plant unit, or subdivision thereof....

29 U.S.C. § 159(b).

Despite the clear directive in Section 9(b) that the Board must determine an appropriate bargaining unit "in each case", the Board proposes to implement a rule which would make eight bargaining units *per se* appropriate in all acute care hospitals, regardless of their size and the complexity of services offered within each facility. In so doing, the Board has overstepped its rulemaking authority because its new bargaining unit rule is directly in conflict with the plain language in the statute. The Rule irrebuttably presumes that certain bargaining units are appropriate without allowing adjudication of substantive issues impacting the appropriate unit determination or consideration

of specific employment facts in each case. Therefore, the Board's Final Rule must be held to be invalid.

This Court has long held that where the language of an act is plain, it must be enforced according to its terms. See *Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain, ... the sole function of the courts is to enforce it according to its terms."); see also *Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980) ("[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.").

All that is required for giving statutory language its conclusive effect is that Congress' intent be expressed with sufficient precision in the act. See *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989) (finding that the inquiry into the meaning of § 506(b) of the Bankruptcy Code should begin and end with the language of the statute itself.); *INS v. Cardoza Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring) ("Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent."); *Commissioner of Internal Revenue v. Asphalt Prods. Co.*, 482 U.S. 117, 121 (1987) ("Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided.").

Also, despite the generally held rule of deference to an agency's interpretation of a statute, the Board's discretion and this Court's deference to the Board's interpretation of Section 9(b) "is constrained by [this Court's] obligation to honor the clear meaning of a statute, as revealed by its language, purpose and history". *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The principle of deference to an agency's construction of a statute has no application where the language of the statute is clear. As stated by this Court in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.

Id. at 842.

As explained by the district court in this case, there is "compelling support" in the legislative history of the National Labor Relations Act to construe Section 9(b) in accordance with its plain and unambiguous meaning, i.e., that bargaining unit determinations "require fact specific inquiries". 718 F. Supp. at 710. The Board should not be allowed to circumvent the plain meaning of Section 9(b) by "creating an ambiguity where none exists". See *Escondido Mut. Water Co. v. La Jolla Band of Mission Indians*, 466 U.S. 765, 781 (1984) (rejecting the court of appeals' purported discovery of an ambiguity in Section 4(e) of the Federal Power Act); *United States v. Turkette*, 452 U.S. 576, 580-81 (1981) (rule of *ejusdem generis* has no application where there is no uncertainty as to the meaning of a particular clause in a statute).

The Board's current interpretation of Section 9(b) should also be rejected in light of its prior conflicting interpretations of its statutory obligation to determine a bargaining unit "in each case". Despite its conclusion now that certain "pre-ordained" bargaining units are *per se* appropriate, the Board has stated many times during adjudicatory proceedings that generalizations as to appropriate bargaining units are not appropriate. See, e.g., *Otis Hosp., Inc.*, 219 N.L.R.B. 164, 165 (1975) ("[N]ot all health care institutions may be exactly alike.... Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise."); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980) (holding that the "in each case" requirement of Section 9(b) precluded a *per se* approach to bargaining unit determinations); *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39, 954 (1984) (finding

that the diverse nature of the health care industry precluded any generalizations as to the appropriateness of particular bargaining units and stating: "No unit is *per se* appropriate and ... separate representation must be justified upon each factual record....").

This Court has rejected requests for deference to agency decisions where the position of the agency has been inconsistent. See *INS v. Cardoza Fonseca*, 480 U.S. at 446 n.30 ("An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."). The NLRB has construed "in each case" language in another statute, the Postal Reorganization Act, as requiring case by case determinations of bargaining units. In *United States Postal Serv.*, 208 N.L.R.B. 948, 952-53 (1974), the Board followed its traditional community of interests analysis in considering the appropriateness of certain bargaining units involving the Postal Service. The Board was persuaded to analyze the petitions on a case by case basis by the language of the Postal Reorganization Act which states: "The National Labor Relations Board shall decide in each case the unit appropriate for collective bargaining in the Postal Service...." 39 U.S.C. § 1202. There can be no rational reason for a departure from a case by case analysis of health care industry petitions where the language of Section 9(b) also mandates that bargaining units be determined "in each case".

The "in each case" language of Section 9(b) clearly requires adjudication of particular facts in each case to determine the appropriate bargaining unit or at least a rule regulating bargaining unit determinations that provides a meaningful opportunity for a health care employer in any particular case to demonstrate that the Rule should not be applied to its hospital. The Seventh Circuit's tortured interpretation of Section 9(b) for purposes of approving the Board's Final Rule should be rejected as contrary to the clear meaning of the statute.

B. Implementation Of The Board's Rule Will Deny Hospitals An Opportunity To Be Heard On The Appropriateness Of Any Specific Bargaining Unit Within Their Facilities

As argued above, Section 9(b) of the Act requires the Board to make a bargaining unit determination "in each case". For many years, the Board has utilized a case by case hearing procedure to determine the appropriate bargaining unit in acute care hospitals. Such a procedure guarantees that each hospital will have the opportunity to be heard on the appropriateness of any proposed bargaining unit. *Amicus curiae* contends that only the Board's case by case representation procedures will provide the appropriate opportunity for health care employers to present evidence relevant to the appropriate bargaining unit question. A case by case determination affords employers the right to be heard in a meaningful manner on important bargaining unit issues and is consistent with the mandate of Section 9(b) of the Act.

In contrast, the Board's Final Rule does not afford a health care employer confronted with a petition for representation the opportunity to argue that only certain bargaining units are appropriate because of the special circumstances of employment in its facility. The Board's Final Rule creates a conclusive presumption that only certain units are appropriate. As stated by the Board during its rulemaking proceeding:

We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers.... Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations....

NPR I, 52 Fed. Reg. 25,142 (1987).

The Board's decision to eschew a rebuttable presumption in favor of a conclusive or irrebuttable presumption creates a rule which is inconsistent with the mandate in Section 9(b) to make bargaining unit determinations "in each case." As argued above, that language mandates consideration of specific facts in each case. Unless interested parties are afforded an opportunity to rebut the presumptions created by the Board's Final Rule, the Board's rulemaking is contrary to the Act and is thus invalid. See *Big Y. Foods, Inc. v. NLRB*, 651 F.2d

40, 45-46 (1st Cir. 1981) (stating that Section 9(b) would invalidate a conclusive presumption because "a conclusive presumption precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees"). The Board has discretion to use rulemaking but only if it is rational and consistent with the Act. See *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 501 (1978); see also Note, *NLRB Guidelines for Determining Health Care Industry Bargaining Units: Judicial Acceptance or Back to the Drawing Board*, 78 Ky. L.J. 143, 158-61 (1989).

The Board's "extraordinary circumstances" exception will not provide an adequate opportunity for individual hospitals to raise issues regarding the appropriateness of any of the mandated bargaining units in their facilities. As mentioned, the Board's extraordinary circumstances exception is extremely narrow. In particular, the Board does not intend to consider increased functional integration between employees or a high degree of work contacts between employees as an extraordinary circumstance meriting relief from the Rule. Similarly, the increased use of team care and cross training of health care professionals which is occurring with increasing frequency in modern acute care hospitals will not be entertained by the Board as an extraordinary circumstance. Differences in the sizes of acute care hospitals, the variety of services offered by each institution, and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. 53 Fed. Reg. 33,932-33 (1988).

Application of the Rule will prevent hospitals like GBMC and Peninsula General from arguing the appropriateness of alternative bargaining units in response to the pending petitions by the MNA. The very factors that make each hospital unique will not be revealed if the Board's new Rule is allowed to be implemented and applied to the pending petitions. For example, the petition for an all RN unit at GBMC will undoubtedly be approved without a specific analysis of employment conditions at GBMC. If the union is successful in convincing registered nurses to vote for representation at GBMC, the hospital will be faced with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at GBMC. The result will be

a fragmentation of the workforce with some professionals working under work rules governed by the collective bargaining agreement while others will be working under the personnel policies of GBMC.

There are many factors which argue in favor of a broader all professional unit at GBMC. The evidence of integration and interaction between registered nurses and other health care professionals at GBMC was presented at the hearing on the bargaining unit issue and need not be repeated in detail here. In brief, however, there are many departments at GBMC where registered nurses are integrated with other health care professionals. For example, registered nurses within the radiology department work with radiology technicians and other allied health care professionals to assist in treatment of patients undergoing intervention radiology. Similarly, in the neonatal unit at GBMC, respiratory therapists work with registered nurses to provide sophisticated care to infant patients within the unit. Operating room procedures at GBMC include a variety of integrated services involving doctors, registered nurses, operating room technicals, laser technicals, pump technicals, and other equipment technicals. In cardiac rehabilitation, physical therapists and registered nurses work together to provide therapy. Registered nurses, dieticians, physicians and pharmacists regularly consult regarding nutrition support issues in an effort to enhance patient care at the hospital. The discharge planner at GBMC is a registered nurse who works with other social workers in advising patients on post-discharge treatment and recovery. Thus, GBMC has substantial evidence of integration between registered nurses and other allied health professionals which should be considered by the Region before it decides that only an all RN unit is appropriate.

In addition to factors demonstrating an integrated professional workforce at GBMC, the hospital also provides identical benefit plans to registered nurses and other allied health professionals. The registered nurses at GBMC share similar education and licensure requirements with other health care professionals. Compensation ranges are comparable for professionals at the hospital. Bonus pay, weekend differential and weekend alternative benefits are paid to allied health professionals as well as registered nurses. Allied health professionals working in direct patient care areas, e.g., respiratory therapists, radiology technologists, and medical technologists often

work the same shifts and get the same percentage differential as registered nurses. Finally, education and training at GBMC is open to coalitions of health-care professionals. It is obvious that the specific conditions of employment at GBMC must be considered prior to any determination of an appropriate bargaining unit. As currently structured, the Board's Final Rule with its "extraordinary circumstances" exception will not provide GBMC the opportunity to demonstrate that an alternative bargaining unit is better suited to the special needs of GBMC.

Similarly, if the Seventh Circuit's decision is not overturned, Peninsula General's argument for an all nonprofessional unit will be ignored by Region 5 and the union's petition for a technical unit will be automatically approved without considering the factors which might make such a unit inappropriate. Again, Peninsula General has argued those factors in a hearing before the Board. The Board, however, will not consider the community of interests between technicals and other nonprofessional employees at Peninsula General if the Final Rule is implemented.

Some of the factors which make a bargaining unit of all nonprofessionals appropriate at Peninsula General include identical benefits, uniform personnel policies, similar scheduling, comparable wages, considerable interaction and integration between service, maintenance, and technical employees, numerous transfers between technical and nontechnical categories, and common supervision. At the hearing on the bargaining unit issue, the hospital was able to demonstrate not only integration of technicals and other nonprofessionals *within* departments (e.g., technical and other nonprofessional members of the nursing team may check vital signs, maintain records, provide colostomy care, transfer patients, feed patients, ambulate patients, secure patient medical records, implement patient safety measures, facilitate performance of diagnostic tests, order medication, and generate documentation of patient care and charges) but also integration of technicals and other nonprofessionals *between* departments.³

³ The detailed information regarding integration and interaction between technicals and nonprofessionals at Peninsula General was culled from Peninsula General's "Brief to the Regional Director on Behalf of Peninsula General Hospital" in Case No. S-RC-13356.

For example, dietary clerks from the food and nutrition services department at Peninsula General tabulate daily menus which are collected from patients by members of the nursing team. Nursing assistants help patients to understand menu selections. Nursing team members, including licensed practical nurses and nursing assistants, communicate physicians' orders regarding specific dietary needs of patients to the dietary staff. Environmental services employees communicate with nursing staff before cleaning rooms to determine whether special precautions are required. Environmental services personnel also provide special cleaning that is required in operating rooms and delivery rooms and coordinate their functions with technical and nonprofessional staff assigned to these areas. Maintenance employees must coordinate their efforts with personnel in patient care and diagnostic areas. Physical therapy aides who assist in transporting patients must interface with members of the nursing team to obtain necessary medical records for documenting the care being provided to patients. Nontechnical members of the nursing team assist technical employees from the lab in drawing blood specimens from difficult or uncooperative patients.

The hospital was also able to demonstrate extensive common supervision at the hearing by showing that forty-two technical and other nonprofessional job classifications had shared supervision. Evidence at the hearing supported the hospital's comparable salary argument in that 129 separate technical and other nonprofessional job classifications shared the same starting rate.

Thus, Peninsula General has made a substantial showing of common interests between technicals and other nonprofessionals in the hearing before the NLRB. The hospital's efforts in this regard will be for naught, however, if the Final Rule is implemented by the Board. The Board's narrow extraordinary circumstances exception will not allow consideration of the factual record established by Peninsula General at the representation hearing. The petition for a technical unit will be approved without consideration of the many factors which militate against adoption of such a unit.

The immediate harm that will result to acute care hospitals as a consequence of the Board's decision to abandon case by case adjudication and resort to a *per se* rule regarding bargaining units is

obvious with hospitals like GBMC and Peninsula General. They are interested parties to representation proceedings yet the Board's Rule will effectively prohibit them from presenting any evidence which might rebut the Board's presumption that only certain bargaining units are appropriate. In these cases, the Rule will have an immediate impact. It can be seen, however, that the proliferation of bargaining units fueled by the Board's Rule and the consequent impact on administrative costs at other hospitals within Maryland also make the Final Rule unjustifiable.

C. The Board's Rule Ignores The Congressional Admonition Against Undue Proliferation Of Bargaining Units In The Health Care Industry

Hospitals within Maryland must regulate their labor relations policies in accordance with the National Labor Relations Act as interpreted by the National Labor Relations Board *and* as enforced by the United States Court of Appeals for the Fourth Circuit. The Fourth Circuit requires each bargaining unit determination of the NLRB to reflect the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). In *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191 (4th Cir. 1982), the NLRB sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The court of appeals rejected the Board's findings because the NLRB did not give due consideration to the issue of proliferation of bargaining units at the hospital. 691 F.2d at 194.

The underlying decision of the Board, *Frederick Memorial Hosp., Inc.*, 254 N.L.R.B. 36 (1981), had upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interest, separate and apart from all other professionals, to justify their own unit for bargaining purposes. The NLRB rejected, however, language in the Regional Director's decision which suggested that the RN unit sought by the union was "*per se* appropriate". The Board stated:

We do not rely on, however, any comments in the Regional Director's decision that may be taken as a conclusion that the registered nurse unit sought here was *per se* appropriate. Our conclusion on the appropriateness of the unit is based on *the particular circumstances involved here*.

Id. at 39 n.12 (emphasis added).

The Court of Appeals for the Fourth Circuit approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

The Board may not depend solely on the traditional community of interest test when making a unit determination for health care institution employees. As other courts have held, the Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination ... implement[s] or reflect[s] that admonition...."

...

A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the court adequately review the Board's decision and order unless the Board clearly discloses why certification of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194 (citations omitted).

The Fourth Circuit recognized in its *Frederick Memorial Hosp.* decision that a unit of registered nurses might not be appropriate in

other hospitals. In this respect, the Fourth Circuit's opinion is clearly at odds with the Seventh Circuit's decision sanctioning the Board's new *per se* approach for bargaining unit determinations. Similarly, the Fourth Circuit requires consideration of the congressional admonition against proliferation in each unit determination and a specific explanation of why certification of a particular unit in each case serves the congressional admonition against unit proliferation. This holding of the Fourth Circuit is again clearly at odds with the Seventh Circuit's decision. See *American Hosp. Ass'n v. NLRB*, 899 F.2d at 658 ("[The admonition] is cautionary rather than directive.").

The Fourth Circuit's recognition of the importance of adhering to the congressional admonition against proliferation is shared by other courts of appeals. See, e.g., *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632 (2d Cir. 1983); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *St. Anthony Hosp. Sys., Inc. v. NLRB*, 884 F.2d 518, 519-20 & n.3 (10th Cir. 1989). Such an approach to bargaining unit determinations is preferred over the abdication of responsibility for proliferation exemplified by the Seventh Circuit's treatment of the NLRB's Final Rule in this case. It is the district court in this case which correctly concluded that the Board by "designat[ing] an absolute number of appropriate units and mandat[ing] a particular division of the workforce was not responsive to Congress' express concern". 718 F. Supp. at 716.

D. The Board's Rule Will Promote A Proliferation Of Organized Units Within Acute Care Hospitals And Multiply Costs For Hospitals Already Faced With Financial Difficulties

The Board's Rule could not have come at a worse time for acute care facilities within Maryland. A recent financial report issued by the MHA reveals that forty-two percent of Maryland hospitals suffered operational losses in the twelve month period ending June 30, 1990, as compared with thirty-seven percent the previous year. Twenty-nine percent of the hospitals incurred losses from operations in both 1989 and 1990. The MHA's report follows on the heels of a February, 1990 report of the Maryland Health Services Cost Review Commission which describes the financial performance of Maryland hospitals

during 1989 as "generally negative - operating and total profits are down - return on total assets is essentially unchanged, and long-term debt has increased".⁴

The Board has stated that it did "carefully consider the Congressional admonition against proliferation" during its rulemaking proceeding and it maintains that its Rule mandating eight units does demonstrate a concern for proliferation. NPR II, 53 Fed. Reg. 33,933. It does not appear, however, that the Board examined the costs of proliferation to acute care hospitals when it decided to move away from its conclusion in *St. Francis Hosp.*, 271 N.L.R.B. 948 (1984), that only a broad professional bargaining unit and a broad nonprofessional unit are appropriate within acute care hospitals unless a smaller unit is justified on the basis of the Board's disparity-of-interests test.

There are eleven acute care hospital members of the MHA which currently have employees represented by unions. The administration and negotiation of collective bargaining agreements with these unions obviously create additional costs for each hospital. Administrative costs are substantial even where there is only one organized unit at a facility. For example, Greater Baltimore Medical Center has assigned one full time equivalent to the administration of its contract with District 1199E. The Director of Personnel also devotes substantial time to the administration of the hospital's contract with the representative of the hospital's service and maintenance employees. The hospital estimates that approximately \$55,000 in direct labor costs are devoted exclusively to administration of the union agreement.

Other Maryland hospitals are likewise incurring extensive costs in administering union agreements at their facilities. For example, Bon Secours Hospital's service and maintenance employees are rep-

⁴ The MHA report showed that the average operating margin of hospitals in Maryland fell from 1.0 percent to 0.9 percent. The study also showed that Maryland hospitals experienced a net profit decline of \$7 million. See Financial Condition Report, Second Quarter, Maryland Hospital Association Information Services, No. 10, 1990. The Maryland Health Services Cost Review Commission is responsible for monitoring hospital charges within Maryland. Its February, 1990 report shows that Maryland hospitals had an operating margin of just .38 percent in 1989, down from .88 percent in 1988. See Report on the Financial Condition of Maryland Hospitals, Health Services Cost Review Commission (Feb. 1990).

resented by Hospital Employees Local No. 1273, an affiliate of the Laborers International Union. Bon Secours' administrative costs have increased because of substantial differences in the union's health insurance plan and the hospital's program, including differences in benefits and procedures under each plan. The hospital also reports that eligibility for leave is different for union and nonunion employees. Vacations and holidays differ for each group. Internal grievance procedures must be administered differently for union and nonunion employees.

Contract negotiations with Local 1273 also substantially increase the hospital's administrative costs. The most recent negotiations with Local 1273 involved eight sessions lasting approximately eight hours each day. Five members of management sit on the negotiating committee with a sixth person available for benefits consultation. The hospital brings an attorney in for the final bargaining session which again adds to the cost of negotiations. The hospital estimates that it expended at least \$13,000 during its contract negotiations with Local 1273. This estimate does not include the hospital's preparation for negotiations which includes meetings with all department managers.

A strike plan is also developed at Bon Secours when negotiations begin on a new contract and such preparations again are time consuming and costly. Strike planning involves all 35 department heads, upper management, the COO of the hospital and the personnel manager. The hospital estimates that there are 80-90 hours involved in strike planning. During its most recent negotiations with the union, the hospital received a § 8(g) notice which obviously enervated the hospital's contingency plan for strikes. Finally, Bon Secours Hospital estimates it may spend 50-55 hours in implementing the new contract. Personnel must meet with managers to explain any changes in the new agreement and there is additional administrative time involved with implementing the details of new economic provisions.

The Johns Hopkins Hospital has also devoted substantial time and resources to administering its service and maintenance unit contract with District 1199E. It estimates that the direct salary cost of administration of the contract in 1990 will be at least \$50,000. This cost estimate includes salaries for Human Resources personnel only.

It does not include the cost of administering the benefits component of the contract or administrative costs relating to the involvement of nursing directors and other managers within the hospital. Negotiations over the agreement require additional costs including legal fees. There are eight people on the negotiating team and each negotiation requires extensive preparation. The hospital estimates its total expenditures during a year when negotiations occur are at least twice that of a normal year.

Sinai Hospital also has a contract with District 1199E which covers its service and maintenance employees. The hospital estimates its annual costs for administering the contract to be approximately \$38,000 a year. During contract negotiations, the Director of Personnel becomes heavily involved in preparing for and participating in the negotiations. The cost of the director's time which is devoted to the negotiations is approximately \$10,000. The total cost for negotiations is substantially more, however, because the Vice President of Employee Relations also gets involved in the negotiations. Preparations for contract negotiations begin four to five months before the contract actually expires. The negotiating team conducts eight to ten meetings with its department heads to develop a consolidated approach to the negotiations. Thus, there is substantial time devoted to negotiation issues by individuals who are not actually part of the negotiating team. Sinai Hospital also prepares a strike contingency plan which involves the collective input of ten to fifteen people including the Vice President of Employee Relations and various department heads. All of this effort must be factored into any analysis of costs for the hospital.

The Francis Scott Key Medical Center in Baltimore has a contract with AFSCME which represents its service and maintenance employees including maintenance employees, nursing aides, housekeeping employees, food service employees, some technicals within the hospital and geriatric nursing assistants. Preparations for negotiations at the medical center begin some six to seven months before the start of talks with the union. The preparation involves the Vice President of Human Resources and two members of her staff. The negotiating team includes representatives from nursing, a representative from the nursing home, a joint housekeeping and dietary administrator, the Employee Relations Manager, the Vice President

of Human Resources and outside counsel. Prior to actual negotiations, the negotiating team will spend almost two weeks finalizing negotiating strategy and examining contract demands. Initial preparation by the team, excluding attorneys' fees, averages about \$8,000 per week. The negotiations usually involve ten to twelve meetings with the union. The hospital estimates its costs for actual negotiations could be as much as \$32,000.

Finally, employees at Prince George's Hospital Center in Cheverly, Maryland, are represented by three different collective bargaining representatives. The Professional Staff Nurses Association represents registered nurses, assistant head nurses, instructors and clinical specialists. Hospital Employees Local 63, International Brotherhood of Firemen and Oilers, represents service, clerical and maintenance employees and licensed practical nurses. PG House Staff Associates represents interns and residents at the hospital. To complicate matters, District 1199E has petitioned the NLRB to represent hospital technicals at Prince George's Hospital Center who are not covered under the Local 63 contract.

Prince George's Hospital Center is a part of Dimensions Health Corporation. The corporation uses the same core team of negotiators for negotiating the contracts with Local 63 and the nurses union but each contract is negotiated separately. Staff salary costs of the negotiating team involved in the negotiations amount to almost \$2000 a day. The bargaining team includes the Senior Vice President of Human Resources, the assistant administrators for human resources of the hospitals in the corporation, and other appropriate administrators. The corporation has scheduled fifteen full days for its reopener negotiations with the nurses union and costs could run over \$30,000 for these negotiations. This figure does not cover the cost of replacing the nurses sitting across the table from the hospital administrators for eight hours a day during the negotiations. The hospital must pay both the nurses on the union's negotiating team and their replacements at each facility.

At Prince George's Hospital Center, the basic salary cost for administering the three separate contracts is \$60,000 a year. This estimate includes only the time of the assistant administrator and the employee relations officer. It does not include the salary cost of the

other managers and executives who must be involved in resolving contract interpretation issues, grievance resolution hearings, ongoing meetings with union leadership and follow-up meetings with the department managers and executives. The hospital estimates that these additional salary expenses could be as much as \$200,000 a year. If the hospital has to go to arbitration with any of the unions, outside counsel is generally involved. Costs then accelerate rapidly because of attorneys' fees.

Preparation for negotiations at Prince George's Hospital Center occurs on several levels. There are meetings between top executives and financial officers where top level management examine the hospital's financial condition and its negotiating strategies for meeting bottom line financial costs. At another level, there are general discussions between the negotiating team and the hospital's senior managers regarding the goals of the hospital during the negotiations. At a third level, there is interaction with sixty department managers to review issues relating to the administration of the old contract and what changes should be made.

Limitations in each union agreement make administration of Prince George's Hospital Center substantially more difficult. Even though there are similar provisions in the contracts, all three groups have separate grievance procedures. Shift differentials and weekend differentials all vary in extent and scope. On call rules also vary which complicate department managers' efforts at operating departments efficiently. There are restrictions on reassignment of employees. Obviously, more avenues for contract violations are open because the hospital is dealing with three separate units and the possibility of inadvertent misapplication of policy. Payroll is an administrative nightmare with different pay policies and scales as well as differences in accrual of vacation time and leave options.

Negotiations with unions and the administration of union contracts create substantial costs for each Maryland hospital which has any organized bargaining units. These costs do not include the disruption which can occur from strikes or from preparation for strikes. Many of the hospitals with unions report that they regularly receive § 8(g) notices during negotiations. Even during organizing, hospitals are subject to work stoppages. A recognition strike can shut down

a hospital as effectively as a strike over economic matters during negotiations.

The Board's Final Rule with its provision for eight different bargaining units is a catastrophe for union and nonunion hospitals alike. Those hospitals which are already experiencing increased costs from administering and negotiating one or more contracts with unions have no doubt that the Board's new Rule will multiply those costs should other units within their hospitals become organized. Other hospitals will eventually be affected by the Rule because unions are poised to take advantage of the prescription for proliferation which is built into the structure of the Final Rule.⁵

The Board's Rule ignores the increase in costs which will be visited upon hospitals after implementation of the *per se* bargaining unit rule. The impact of proliferation cannot be measured simply by counting the number of hospital units that ultimately might be created by operation of the Final Rule. Even the addition of one unit could place a serious burden on hospitals already substantially burdened with costs associated with negotiating and administering union agreements. The administrative costs outlined above could be doubled, tripled or, in the worst case scenario, octupled by operation of the Board's Rule. Instead of having to administer a broad service and maintenance unit with just one union, hospitals organized under the new Rule may have to negotiate with three different unions and administer three separate contracts. The Board has given short shrift to the congressional admonition against proliferation and hospitals in Maryland will pay the consequences.

E. The Board's Rule Is Arbitrary And Capricious Because It Applies To All Hospitals In Maryland Regardless Of Their Size And The Diversity Of Services Offered At Each Facility

⁵ The National Union of Hospital and Health Care Employees recently announced that it would triple its 28,000 member dues in order to finance a massive, nationwide organizing campaign in 1991. The union expects this Court to approve the Board's Final Rule and, in response, it will add 400 more organizers to undertake what the union calls "the largest mobilization for organizing ever undertaken by the American labor movement." See 213 Daily Labor Report (BNA) at p. A-18 (11-2-90).

The Board has concluded that its Final Rule should apply to all acute care hospitals regardless of hospital size and the variety of services offered by individual institutions. While conceding that the health care industry is comprised of a "multiformity of individual constituent institutions", the Board attempted to justify the application of a *per se* rule to all hospitals by dismissing the differences among acute care hospitals as merely "minor differences". See NPR II, 53 Fed.Reg. 33,932. To describe the diversities in health care facilities as only minor differences is extremely myopic. The Board's decision to apply the Rule to all acute care hospitals is arbitrary and capricious because it ignores the impact of size and the complexity of services within each facility on the community of interests of employees at each facility.

Member hospitals within the MHA are extremely varied in size. For example, Johns Hopkins has over 6,000 employees and 952 beds while a rural hospital like Kent & Queen Anne's Hospital has 300 employees and only 64 beds. Johns Hopkins' operating budget is over 20 times greater than the operating budget of Kent & Queen Anne's Hospital. App., *infra*, p. 6a. Johns Hopkins has over 1,500 registered nurses while Kent & Queen Anne's Hospital employs approximately 80 registered nurses. Similarly, the University of Maryland Medical System ("UMMS") in Baltimore, Maryland, has 747 beds while the Edward W. McCready Memorial Hospital ("McCready Memorial") in Crisfield, Maryland, has 41 beds.

Size is not the only difference between large urban institutions like Johns Hopkins and UMMS and smaller rural hospitals within Maryland. Johns Hopkins and UMMS are tertiary care facilities with many departments providing specialized care to patients with severe injuries and illnesses. Health care professionals assigned to these specialty units are likely to have more in common with each other than with similarly licensed professionals within the hospital. For example, registered nurses assigned to the oncology department within Johns Hopkins are likely to have more in common with the social workers in the department than with registered nurses in other departments of the hospital. Similarly, health care professionals in the shock trauma center at UMMS or in the cancer center will undoubtedly have special interests arising out of their employment in such tertiary care units which would undercut the assumptions underlying the Board's

per se rule. Nurses within the neonatal unit at St. Agnes Hospital may have more in common with the doctors, respiratory therapists and physical therapists working in the unit than with nurses providing general patient care at St. Agnes. The Board's assumption that registered nurses all have similar working conditions and interests is extremely naive when viewed in the context of large metropolitan hospitals with specialized units.

In contrast, rural hospitals like Kent & Queen Anne's Hospital and McCready Memorial are much smaller community hospitals. Although each hospital provides quality care to its patients, it does not have the resources to staff and equip a tertiary care unit. Thus, registered nurses within smaller hospitals may in fact have similar duties. Nevertheless, the smaller size of these hospitals increases the integration and interaction between nurses and other allied health professionals throughout the hospital. This is also true of service and maintenance employees in a small hospital. The limited resources of the smaller hospital may require employees to perform a number of different service and maintenance functions which make the Board's mandated division of service and maintenance employees into a technical unit, a skilled maintenance unit and a nonprofessional employee unit arbitrary and capricious as it is applied to a smaller facility.

The Board's Rule also ignores the differences between professionals in psychiatric units or rehabilitation units within acute care hospitals. The Board has stated that to the extent that the acute care hospitals have psychiatric sections, these hospitals are not excluded from the application of the Rule unless the psychiatric sections predominate. 53 Fed. Reg. 33,930. Thus, registered nurses working within psychiatric units at acute care hospitals would be included in the RN unit even though they are giving more specialized care to patients than registered nurses working with patients in the general treatment areas of the hospital. Similarly, the Rule ignores hospitals which have rehabilitation units. In rehabilitation departments, social workers, physical therapists, occupational therapists, psychologists and registered nurses all work together to help patients with traumatic injuries cope with the necessary changes in their life style. The Rule mandates that nurses within such a unit be set apart from other professionals in an all RN bargaining unit regardless of the similarities

in terms and conditions of employment between these nurses and other allied health professionals in the rehabilitation unit.

The Board's rationale for adopting its Final Rule for acute care hospitals makes even less sense when it is contrasted with the Board's stated reasons for excluding nursing homes from the application of the Rule. The Board concluded that the Rule should not apply to nursing homes because there were not only substantial differences between nursing homes and hospitals but "*significant differences between the various types of nursing homes which affect staffing patterns and duties*". 53 Fed. Reg. 33,928. The Board said:

In the absence of a measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units.... We therefore conclude that it is best to continue a case by case approach with respect to nursing homes."

Id. at 33,928-33,929.

It is amazing that the Board found differences between nursing homes to be significant enough to merit continuation of the case by case unit determination process while the many differences between acute care hospitals were deemed to be "minor" differences. The Board's reasoning is arbitrary and capricious in this respect and will only result in disruption and upheaval in acute care hospitals if the Rule is allowed to be implemented.

F. The Board's Rule Is Arbitrary And Capricious Because It Ignores The Integration And Interaction Of Health Care Employees Within Maryland Hospitals

The Board's Final Rule ignores the trend toward increased integration of professionals in Maryland hospitals. The Rule ignores the increased focus on team care within Maryland hospitals and established mechanisms for collaborative care within each hospital. The examples of such interdisciplinary concepts for patient care and the integration of professionals within Maryland hospitals are numerous. The Final Rule, however, will not allow any hospital to demonstrate that its team approach to health care makes the Board's mandated bargaining units inappropriate for its facility.

Hospitals within Maryland almost uniformly utilize various strategies for collaborative care of patients within their facilities. Whether the planning device or concept is labeled "critical path", "collaborative committee for patient care", or "interdisciplinary committee on patient care", the result is the same: a team approach to patient care at the hospital. From the moment the patient enters the hospital, a plan begins to take shape for effective and efficient care during the patient's stay at the hospital. Physicians, registered nurses, dietitians, pharmacists, social workers, and other allied health professionals coordinate their efforts and implement an integrated method for dealing with the patient's illness. Patients with unique illnesses or injuries may be scrutinized by an interdisciplinary study group. Quality assurance is also a coordinated program with extensive interaction between health care professionals.

Many hospitals utilize nutrition support teams to supplement the patient care plan. Doctors, registered nurses and dietitians meet and discuss nutritional support for enhancing and accelerating the patient's recovery. Pharmacists are also consulted so that the patient's diet is compatible with prescribed medicines. Doctors may order a special nutritional assessment to determine the nutritional needs of a patient with the result that dietitians and the nursing staff must evaluate the patient's diet and eating habits.

At the conclusion of a patient's stay, many Maryland hospitals will have facilitated resolution of specific issues relating to the patient's discharge with the help of discharge planning teams. These teams usually involve physicians, social workers, registered nurses and pharmacists who advise patients upon their departure from the acute care facility and help transition them to complete recovery.

Patients in Maryland hospitals are also likely to be exposed to many health care professionals during their stay at the hospital. Patients care areas will be visited by physicians, registered nurses, respiratory therapists, phlebotomists, pharmacists and social workers. Social workers and mental health counselors will be asked to intervene in cases involving child or spousal abuse. A hospital may use "rounds", clinical care committees, or more informal discussion groups to chart and enhance patient progress.

Other departments within acute care hospitals demonstrate the integration and interaction of health care professionals. Delivery of emergency care is very much a team effort with nurses, physicians and x-ray technologists treating the same patients. Operating rooms have historically utilized teams of professionals to provide surgical expertise. With increasing frequency, pharmacists are assigned to nursing units in various satellite pharmacies to increase coordination and delivery time of medicine to hospital patients. Pharmacists may also input the doctors' orders regarding medication and counsel patients regarding the medicines they will be taking. It is not uncommon for registered nurses to be working in labs with medical technologists, in cardiovascular services departments along side cardiovascular technologists, in rehabilitation units with physical therapists and occupational therapists, in mental health units with mental health counselors and social workers, or in radiology departments with x-ray technicians.

The integration and interaction of health care professionals are very important factors that should be explored by the Board before it applies its arbitrary bargaining unit rule to isolate registered nurses from other health care professionals in an otherwise integrated workplace. A case by case adjudication of appropriate bargaining units would reveal that health care professionals in Maryland hospitals participate in common benefit plans and work under uniform personnel policies. They have comparable salaries, receive identical bonus pay, work similar schedules, and receive identical shift differential.

Interdisciplinary training is accomplished through collaborative practice groups. Health care professionals work together on various hospital committees and may give in-service training to each other in their respective specialties. Interaction of employees is stimulated further by training sessions on more generic subjects such as infection control, CPR training, stress management, hazard abatement, or EAP opportunities.

Health care professionals in acute care hospitals in Maryland cannot be collated and sorted into different "pigeon holes". An interdisciplinary approach to patient care is alive and well in Maryland and the Board's Final Rule, with its extremely narrow "extraordinary circumstances" exception, simply does not allow the similarities in

wages, hours and working conditions of hospital personnel to be revealed. The Board should continue its case by case approach (just as it plans to do for other industries), so that the special circumstances of employment for health care personnel can be illuminated "in each case".

IV. CONCLUSION

For all the foregoing reasons, and for the reasons stated in the brief of the American Hospital Association, the decision of the Seventh Circuit should be reversed.

Respectfully submitted,

By: _____

JOHN G. KRUCHKO*

PAUL M. LUSKY

KRUCHKO & FRIES

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Attorneys For Amicus Curiae

The Maryland Hospital

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***Counsel of Record**

APPENDIX

1a '

**U.S. Department of Justice
Office of the Solicitor General**

October 24, 1990

Paul M. Lusky
Kruchko & Fries
Counselors at Law
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

Re: *American Hospital Association v. NLRB*
No. 90-97

Dear Mr. Lusky:

In response to your letter of October 23, 1990, I hereby consent to the filing in the above-captioned case of an *amicus curiae* brief on behalf of the Maryland Hospital Association.

Sincerely,

/s/ Kenneth W. Starr
Solicitor General

2a

Dickstein, Shapiro and Morin

October 24, 1990

Paul M. Lusky, Esquire
Kruchko & Fries
606 Towson Towers
28 West Allegheny Avenue
Baltimore, Maryland 21204

RE: *American Hospital Association v. N.L.R.B.*, et al.
No. 90-97

Dear Mr. Lusky:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of the Maryland Hospital Association.

Sincerely,

/s/ Woody N. Peterson

WNP:hmp

3a

**American Federation of Labor and
Congress of Industrial Organizations**

October 29, 1990

Mr. John G. Kruchko
Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive
McLean, Virginia 22102

Dear Messrs. Kruchko & Lusky:

Re: *American Hospital Association v. NLRB, et al.*
(Supreme Court No. 90-97)

The American Federation of Labor and Congress of Industrial Organizations hereby consents to the timely filing of an *amicus curiae* brief in support of the petitioner in the above-referenced matter on behalf of the Maryland and Virginia Hospital Associations.

Sincerely yours,

/s/ David M. Silberman
Associate General Counsel

4a

Mayer, Brown and Platt

October 17, 1990

Paul M. Lusky, Esq.
 Kruchko & Fries
 7929 Westpark Drive, Suite 202
 McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*

Dear Mr. Lusky:

On behalf of the American Hospital Association, I hereby consent to the filing of a brief *amicus curiae* by the Fairfax Hospital System, et al. in the above-referenced case.

Sincerely,

/s/ James D. Holzhauer

JDH:cml

5a

MARYLAND HOSPITALS CHART¹

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Anne Arundel Medical Center Annapolis, MD	1782	303	\$58,787,400	U
Bon Secours Hospital Baltimore City, MD	980	192	39,744,000	U
Children's Hospital & Center for Reconstructive Surgery Baltimore City, MD	323	68	13,076,900	U
Church Hospital Baltimore City, MD	999	216	44,838,000	U
Francis Scott Key Medical Center Baltimore City, MD	2200	564	78,092,500	U
Franklin Square Hospital Center Baltimore City, MD	2313	427	89,553,300	U
Good Samaritan of Maryland Baltimore City, MD	1211	238	46,583,500	U
Greater Baltimore Medical Center Baltimore County	2200	352	93,858,200	U
Harbor Hospital Center Baltimore City, MD	1377	283	\$68,996,500	U

¹ Figures were derived from the most recent data supplied by the Maryland Health Services Cost Review Commission and, when possible, from data supplied by individual hospitals.

* The characterization of hospitals as "Urban" in this appendix parallels the designation "Metropolitan" used by the Maryland Health Services Cost Review Commission in its data.

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MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Homewood Hospital Center Baltimore City, MD	1055	267	61,035,700	U
James Lawrence Kernan Hospital	299	66	12,723,900	U
Johns Hopkins Hospital Baltimore City, MD	6125	952	257,584,900	U
Liberty Medical Center Baltimore City, MD	811	282	47,733,900	U
Maryland General Hospital Baltimore City, MD	1250	213	55,368,500	U
Mercy Medical Center Baltimore City, MD	1319	290	65,466,800	U
Sinai Hospital of Baltimore Baltimore City, MD	2700 FTE	467	125,923,300	U
St. Agnes Hospital of the City of Baltimore Baltimore City, MD	2800	430	93,370,600	U
Union Memorial Hospital Baltimore City, MD	1881	349	88,364,600	U
University of Maryland Medical System Baltimore City, MD	3160	669	211,603,000	U
Suburban Hospital Bethesda, MD	1600	282	61,389,600	U

7a

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Dorchester General Hospital Cambridge, MD	363	114	14,511,900	R
Kent & Queen Anne's Hospital Chestertown, MD	300	64	10,543,000	R
Prince George's Hospital Center Cheverly, MD	1800	423	85,227,800	U
Southern Maryland Hospital Clinton, MD	1092	308	54,267,600 (1988)	U
Howard County General Hospital Columbia, MD	1109	194	41,251,000	U
Edward W. McCready Memorial Hospital Crisfield, MD	200	41	4,279,900	R
Memorial Hospital & Medical Center Cumberland, MD	1100	214	37,144,100	R
Sacred Heart Hospital Cumberland, MD	1022	240	33,875,200 (1988)	R
Memorial Hospital Easton, MD	1000	201	31,947,000	R
Union Hospital of Cecil County Elkton, MD	619	139	25,272,600	R

8a

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Fallston General Hospital Fallston, MD	662	152	25,377,500 (1988)	U
Frederick Memorial Hospital Frederick, MD	1338	235	45,385,700	R
Frostburg Community Hospital Frostburg, MD	148	47	5,430,000	R
North Arundel General Hospital Glen Burnie, MD	1304	285	51,335,700	U
Washington County Hospital Hagerstown, MD	1706	304	57,281,700	R
Harford Memorial Hospital Havre De Grace, MD	610	205	23,413,800 (1988)	R
Physicians Memorial Hospital La Plata, MD	448	104	19,078,300	R
AMI Doctors' Hospital Lanham, MD	880	250	51,657,800	R
Greater Laurel Beltsville Hospital Laurel, MD	738	184	28,733,500	U
St. Mary's Hospital Leonardtown, MD	447	107	18,139,200	R
Garrett County Memorial Hospital Oakland, MD	323	76	10,964,600	R

9a

MARYLAND HOSPITALS CHART (continued)

Acute Care Facility	No. of Employees	No. of Beds	Operating Budget (1989 Act.)	Urban v. Rural
Montgomery General Hospital Olney, MD	1045	229	39,079,900	U
Calvert Memorial Hospital Prince Frederick, MD	400	157	18,803,200	R
Baltimore County General Hospital Randallstown, MD	1325	220	47,262,600	U
Leland Memorial Hospital Riverdale, MD	416	107	18,700,200 (1988)	U
Shady Grove Adventist Hospital Rockville, MD	1371	233	54,539,800 (1988)	U
Peninsula General Hospital Medical Center Salisbury, MD	1767	360	68,838,100	R
Holy Cross Hospital of Silver Spring Silver Spring, MD	2000	452	87,002,700	U
Washington Adventist Hospital Takoma Park, MD	1487	300	70,995,700 (1988)	U
St. Joseph Hospital Towson, MD	2045	415	89,913,100	U
Carroll County General Hospital Westminster, MD	882	118	25,080,800	R

**MARYLAND HOSPITALS WITH
COLLECTIVE BARGAINING UNITS**

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Bon Secours Baltimore City, MD	Hospital Employees Local Union No. 1273, District Council of Baltimore & Vicinity, Laborers' In- ternational Union of North America, AFL- CIO	Service, main- tenance, some clerical employees
Greater Baltimore Medical Center Baltimore County, MD	District 1199-E, Na- tional Union of Hospi- tal & Health Care Employees - SEIU	Service and maintenance employees
Greater Laurel- Beltsville Hospital Laurel, MD	Maryland Nurses As- sociation, Staff Nurses Professional Chapter	RNs, assistant head nurses, in- structors, clini- cal specialists
	Hospital Employees Local 63, Internation- al Brotherhood of Firemen & Oilers, AFL-CIO	Service, cleri- cal, main- tenance employees, LPNs
Johns Hopkins Hospital Baltimore, MD	District 1199-E, Na- tional Union of Hospi- tal & Health Care Employees - SEIU	Service and maintenance employees

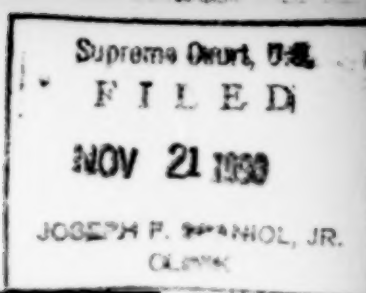
**MARYLAND HOSPITALS WITH
COLLECTIVE BARGAINING UNITS
(continued)**

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Howard County General Hospital Columbia, MD	Local 27, United Food and Commercial Workers Union	RNs
	Local 27	Nonprofes- sional employees
Francis Scott Key Medical Center Baltimore City, MD	American Federation of State, County, and Municipal Employees, Council 67 and Local 44	Service and maintenance employees, LPNs
Liberty Medical Center Baltimore City, MD	District 1199-E, Na- tional Union of Hospi- tal & Health Care Employees - SEIU Maryland Nurses As- sociation	Service and maintenance employees, LPNs RNs, on-call float pool nur- ses
Maryland General Hospital Baltimore City, MD	District 1199-E, Na- tional Union of Hospi- tal & Health Care Employees-SEIU	Service and maintenance employees

**MARYLAND HOSPITALS WITH
COLLECTIVE BARGAINING UNITS
(continued)**

Hospital	Collective Bargaining Representative(s)	Categories of Employees Represented
Physicians Memorial Hospital La Plata, MD	Southern Maryland Healthcare Employees Association, Local 1182, Service Employees Interna- tional Union, AFL- CIO	RNs and LPNs
Prince George's Hospital Center Cheverly, MD	Maryland Nurses As- sociation, Staff Nurses Professional Chapter Hospital Employees Local 63, Internation- al Brotherhood of Firemen & Oilers, AFL-CIO PG House Staff As- sociates	RNs, assistant head nurses, in- structors, clini- cal specialists; Service, cleri- cal and main- tenance employees, LPNs; Interns, Resi- dents and Fel- lows
Sinai Hospital of Baltimore Baltimore City, MD	District 1199-E, Na- tional Union of Hospi- tal & Health Care Employees-SEIU	Service and maintenance employees

(13)
No. 90-97



In The
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.
Respondents

On Petition For A Writ Of Certiorari To The
United States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF
THE FAIRFAX HOSPITAL SYSTEM

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No. 90-97

In The
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.
Respondents

On Petition For A Writ Of Certiorari To The
United States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF
THE FAIRFAX HOSPITAL SYSTEM

I. INTEREST OF THE AMICUS CURIAE

The Fairfax Hospital System submits its brief as *amicus curiae* in support of the Petitioner, the American Hospital Association.¹ Petitioner in this matter challenges the legitimacy of the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry (hereinafter "Final Rule" or the "Rule"). 54 Fed. Reg. 16,347-16,348, 29 C.F.R. § 103.30 (1989). The Fairfax Hospital System believes it can illuminate the disruption and as-

¹ All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

sociated costs that will occur if the Seventh Circuit's decision vacating the injunction against implementation of the Rule is upheld. This *amicus curiae* brief will demonstrate the practical impact of the Board's Final Rule on acute care hospitals throughout this country.

The Fairfax Hospital System consists of four affiliated nonprofit hospitals located in the Washington, D.C. suburbs of Northern Virginia. The hospitals include (1) Fairfax Hospital, located in Falls Church, Virginia; (2) Fair Oaks Hospital, located in Fairfax, Virginia; (3) Jefferson Hospital, located in Alexandria, Virginia and (4) Mount Vernon Hospital, also located in Alexandria, Virginia. The Fairfax Hospital System employs over 7,000 health care workers. The largest of the hospitals in the System is Fairfax Hospital with over 4,600 employees. Mount Vernon Hospital has approximately 1,200 employees, whereas Fair Oaks Hospital has 850 employees. Jefferson Hospital is the smallest of the hospitals within the Fairfax Hospital System employing approximately 420 individuals. The four hospitals, despite a great disparity in size and complexity of organization, all come within the definition of "acute care" hospital as set forth in the Board's Final Rule.

All employees of the Fairfax Hospital System are currently nonunion. On January 17, 1990, however, a petition was filed in Region 5 of the National Labor Relations Board ("NLRB") by the District of Columbia Nurses Association ("DCNA"). By this petition, designated Case No. 5-RC-13331 by the NLRB, the DCNA seeks to represent a unit of approximately 1,200 registered nurses within Fairfax Hospital. The Regional Director for the NLRB's 5th Region has been prevented from taking any action on the petition because of the injunction issued by the United States District Court for the Northern District of Illinois on July 25, 1989. The United States Court of Appeals for the Seventh Circuit vacated the injunction against enforcement of the Board's Final Rule on April 11, 1990. The American Hospital Association gained a stay of that order pending the decision of this Court on the petition for a writ of certiorari. This Court granted the petition for a writ of certiorari on October 9, 1990.

If the Seventh Circuit's decision is not reversed, however, it is expected that Region 5 will move quickly to apply the Board's Final Rule to the petition filed by the DCNA and certify the proposed unit

of registered nurses as an appropriate bargaining unit without considering the special conditions of employment at Fairfax Hospital. Application of the Final Rule will preclude Fairfax Hospital from exploring the appropriateness of alternative bargaining units during the representation proceeding. The Seventh Circuit's decision to dissolve the injunction against the Board's Final Rule also raises the specter of 32 possible units within the Fairfax Hospital System, the potential for jurisdictional disputes between unions competing for membership within the System, and the potential for dramatic increases in administrative costs for the Fairfax Hospital System as a consequence of having to negotiate and administer contracts with many different unions within the Fairfax Hospital System.

The potential fragmentation of its work force is particularly alarming to Fairfax Hospital because it operates a highly integrated health care system which promotes a great degree of contact between registered nurses and other allied health professionals. The Hospital utilizes a team approach to health care and is organized along service department lines rather than artificially according to the various professions working within the facility. The Hospital's registered nurses work side-by-side with physicians, respiratory therapists, physical therapists, dieticians, occupational therapists, speech pathologists, pharmacists, social workers, medical technologists, cardiovascular technologists, radiation oncology technologists, and x-ray technologists. Many of these allied health professionals share common management with the registered nurses at the Hospital. They have similar education, training and licensure requirements. Their salaries are comparable to the registered nurses at the Hospital and they participate in common benefit plans of the Fairfax Hospital System.

The Fairfax Hospital System believes the determination of an appropriate bargaining unit for any group of organized employees at Fairfax Hospital must take into consideration the integrated nature of the Hospital's staff. Application of the Board's Final Rule, however, to the pending representation petition will preclude any adjudication of the appropriateness of an alternative bargaining unit. Fairfax Hospital will not have an opportunity to rebut the Board's conclusive presumption as to the appropriateness of an all RN unit. The Fairfax Hospital System is, thus, vitally interested in the issues presented by

this case and it supports the position of the American Hospital Association in urging reversal of the Seventh Circuit's decision.

II. SUMMARY OF THE ARGUMENT

This case presents the important issue of whether the NLRB will be allowed to promulgate and apply a rule mandating that only eight bargaining units are appropriate within acute care hospitals regardless of differences in their size, location or operations. The Fairfax Hospital System contends that the Board's Final Rule, and its *per se* application to all representation petitions relating to acute care hospitals, including the petition for representation of registered nurses at Fairfax Hospital, is contrary to the congressional admonition contained in the legislative history of the Health Care Amendments Act of 1974. Further, the Final Rule is in conflict with Section 9(b) of the National Labor Relations Act (the "Act") which requires the Board to decide appropriate bargaining units "in each case". 29 U.S.C. § 159(b). The Board cannot exercise its rulemaking authority in a manner which is inconsistent with the Act. That is exactly the manner in which the Board has proceeded, however, by promulgating a rule which precludes individual acute care hospitals from demonstrating that the special circumstances of employment at their facilities merit consideration of alternative bargaining units than those determined to be *per se* appropriate in the Rule.

The Board's Final Rule provides for eight bargaining units within acute care hospitals. This is true regardless of the size or complexity of operations of any particular hospital. The NLRB makes clear that the eight appropriate units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units mandated by the Rule include: "(1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16,347-16,348, 29 C.F.R. § 103.30.

The Board's "extraordinary circumstances" exception is extremely narrow. The Board has stated that it will not consider additional evidence or arguments that a particular hospital varied from the norm, even if the variation is "highly unusual". See Second Notice of

Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33,932-33 (1988). Hospitals bear a "heavy burden" to demonstrate that extraordinary circumstances exist which make the *per se* Rule inappropriate. *Id.* at 33,933. In particular, the Board has stated that "increased functional integration of and a higher degree of work contacts between, employees as a result of the advent of a multi-competent worker, increased use of 'team' care and cross training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also not be given weight as extraordinary circumstances meriting relief from the Rule. *Id.*

The Board's Final Rule is thus arbitrary and capricious in that its application would ignore the special circumstances of employment at Fairfax Hospital and threatens to disrupt the Hospital's team concept for delivery of quality health care at the institution. In effect, the Board has created a conclusive presumption as to the appropriate bargaining unit at Fairfax Hospital without affording the Hospital an opportunity to rebut the presumed appropriateness of a separate RN unit which is implicit in the Rule. The Hospital will be denied a meaningful opportunity to argue the appropriateness of an alternative bargaining unit in response to the petition of the DCNA. The arbitrariness of the Board's Rule is underscored by its potential application to all acute care hospitals within the Fairfax Hospital System regardless of their size or the complexity of services offered at each institution. The harm visited by the Board's Final Rule on acute care hospitals like Fairfax Hospital and on health care systems like the Fairfax Hospital System can only be avoided by reversal of the Seventh Circuit's decision and reinstatement of the district court's permanent injunction prohibiting implementation of the Rule.

III. ARGUMENT

Petitioner in this case, the American Hospital Association, challenged the Board's Final Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court issued a permanent injunction barring its enforcement. *American Hospital Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule was in conflict with the

congressional admonition to give due consideration to preventing proliferation of bargaining units in the health care industry. The court said:

A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

718 F. Supp. at 716.

Because the district court concluded that the Board's Final Rule was contrary to the congressional admonition, it did not resolve the specific issue of whether the Board's Rule was invalidated by the "in each case" requirement of Section 9(b), finding only that Section 9(b) does not entirely foreclose the Board from promulgating rules regarding appropriate bargaining units. 718 F. Supp. at 716. For the same reason, the district court did not address the American Hospital Association's claim that the Rule was arbitrary and capricious.

Respondents appealed the district court's decision to the Seventh Circuit Court of Appeals. In *American Hosp. Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed the decision of the district court and vacated the injunction. 899 F.2d at 660. The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case by case determination of bargaining units. The court also held that the Rule was not precluded by the congressional admonition against proliferation of bargaining units in the health care field. Finally, the court of appeals rejected the American Hospital Association's argument that the Final Rule was arbitrary and capricious because it failed to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 659.

The Seventh Circuit's decision in *American Hosp. Ass'n v. NLRB* will have a direct and immediate effect on the Fairfax Hospital System. If the decision is allowed to stand, the Board will no longer be prohibited from applying its Final Rule to representation petitions within the health care industry. The Board will undoubtedly approve

the DCNA's petition for an all RN unit at Fairfax Hospital without considering the special facts of employment at Fairfax Hospital. The Board will also not determine whether the application of the Rule would result in an unnecessary proliferation of units within Fairfax Hospital and ultimately within the Fairfax Hospital System.

Unless the NLRB's Final Rule is rejected as invalid, Fairfax Hospital will not be able to bring to light the special circumstances of employment at the Hospital. The application of the Final Rule to the pending petition of the DCNA forecloses the possibility that a unit other than an all RN unit will be considered as appropriate for bargaining at Fairfax Hospital. The result will be an unnecessary fragmentation of employees within the Hospital with registered nurses governed by different work rules than those applied to other professionals within the Hospital. The Hospital will be required to administer different wages and benefit plans for professionals working side by side. Should different unions organize separate groups of employees at Fairfax Hospital along the lines suggested by the Final Rule, the contracts dealing with all such relationships between the Hospital and the unions will likely expire at different times. Negotiations will also occur at different intervals. The Fairfax Hospital System's goal of coordinated delivery of health care will likely be thwarted by internal disputes between unions. Delivery of health care to Fairfax Hospital's patients will not be as efficient and may result in unnecessary harm to these patients.

A. The Board's Rule Ignores The Congressional Admonition Against Undue Proliferation Of Bargaining Units In The Health Care Industry

The Fairfax Hospital System, located as it is within Northern Virginia, must regulate its labor relations policies in accordance with the National Labor Relations Act as interpreted by the National Labor Relations Board and as enforced by the United States Court of Appeals for the Fourth Circuit. The Fourth Circuit requires each bargaining unit determination of the NLRB to reflect the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d

Cong., 2d Sess. 6-7 (1974). In *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191 (4th Cir. 1982), the NLRB sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The court of appeals rejected the Board's findings because the NLRB did not give due consideration to the issue of proliferation of bargaining units at the hospital. *Id.* at 194.

The Board's decision, *Frederick Memorial Hosp., Inc.*, 254 N.L.R.B. 36 (1981), upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interest, separate and apart from all other professionals, to justify their own unit for bargaining purposes. Finding differences in licensure and training requirements, vacation pay, overtime payments, organizational structure, and other working conditions between the registered nurses and the other professionals, the Regional Director concluded that a separate unit of nurses was appropriate. In particular, the Board emphasized the fact that the vast majority of the registered nurses at Frederick Memorial Hospital were administratively separated into a nursing division which promulgated its own work policies and procedures. The registered nurses reported to different supervisors than the other professionals at the hospital and they also lacked extensive contact with other professionals. 254 N.L.R.B. at 38.

The NLRB thus rejected the hospital's attempt to include thirty-six other health care professionals into the unit of 158 registered nurses. The NLRB also rejected, however, language in the Regional Director's decision which suggested that the RN unit sought by the union was "*per se* appropriate". The Board stated:

We do not rely on, however, any comments in the Regional Director's decision that may be taken as a conclusion that the registered nurse unit sought here was *per se* appropriate. Our conclusion on the appropriateness of the unit is based on *the particular circumstances involved here*.

Id. at 39 n.12 (emphasis added).

The Board's opinion in *Frederick Memorial Hosp.* discussed the fact that the Regional Director had made a detailed analysis of the working conditions of the registered nurses and the other allied profes-

sionals at the hospital before concluding that the RN unit was appropriate. The Board said:

Here, while the Regional Director issued his decision in the underlying representation case without the benefit of *Newton-Wellesley*, he did receive and consider all the evidence presented by the parties concerning the alleged appropriateness of the petitioned-for unit of registered nurses. Here, unlike the situation in *St. Francis Hospital of Linwood*, all parties at the hearing in the representation case encouraged the taking of testimony concerning the appropriateness of a registered nurse unit. With all evidence having been adduced that the parties deemed relevant, the Regional Director in his decision then concluded that the requested unit of registered nurses here was an appropriate unit for collective bargaining.

Id. at 37.

The *Frederick Memorial Hosp.* decision demonstrates that both the Regional Director and the Board analyzed the working conditions within the hospital in detail before concluding that the unit of registered nurses was appropriate. The Court of Appeals for the Fourth Circuit approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

The Board may not depend solely on the traditional community of interest test when making a unit determination for health care institution employees. As other courts have held, the Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination ... implement[s] or reflect[s] that admonition"

...

A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the court adequately review the Board's decision and order unless the Board clearly discloses why certification of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194 (citations omitted).

The Fourth Circuit recognized in its *Frederick Memorial Hosp.* decision that a unit of registered nurses might not be appropriate in other hospitals. *Id.* In this respect, the Fourth Circuit's opinion is clearly at odds with the Seventh Circuit's decision sanctioning the Board's new *per se* approach for bargaining unit determinations. Similarly, the Fourth Circuit requires consideration in each health care unit determination of the congressional admonition against proliferation and a specific explanation of why certification of a particular unit *in each case* serves the congressional admonition against unit proliferation. This holding of the Fourth Circuit is again clearly at odds with the Seventh Circuit's decision. *See American Hosp. Ass'n v. NLRB*, 899 F.2d at 658 ("[The admonition] is cautionary rather than directive").

The Fourth Circuit's recognition of the importance of adhering to the congressional admonition against proliferation is shared by other courts of appeals. *See, e.g., Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632 (2d Cir. 1983); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *St. Anthony Hosp. Sys., Inc. v. NLRB*, 884 F.2d 518, 519-20 and n.3 (10th Cir. 1989). This approach to bargaining unit determinations is preferable to the abdication of responsibility for avoiding proliferation exemplified by the Seventh Circuit's treatment of the NLRB's Final Rule in this case.

B. The Plain Language Of The Act Requires A Bargaining Unit Determination In Each Case

For over fifteen years, the NLRB has determined the appropriateness of bargaining units in acute care hospitals on a case by case basis. During numerous representation proceedings, the Board indicated its disdain for generalizations regarding appropriate bargaining units in the health care industry. *See, e.g., St. Francis Hosp.*, 271 N.L.R.B. 948, 953 (1984). Then, on the eve of an organizing drive by the DCNA at Fairfax Hospital, the NLRB decided to create a rule which makes an all RN unit *per se* appropriate in all acute care hospitals. The Board took such action even though the language of the National Labor Relations Act mandates a factual inquiry into the particular conditions of employment at each hospital before certifying a unit as appropriate for bargaining.

Section 9(b) of the National Labor Relations Act provides in pertinent part:

The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, plant unit, or subdivision thereof....

29 U.S.C. §159(b) (emphasis added).

Despite the clear directive in Section 9(b) that the Board must determine an appropriate bargaining unit "in each case", the Board proposes to implement a rule which would make eight bargaining units *per se* appropriate in all acute care hospitals, regardless of their size or the complexity of their organization. In so doing, the Board has overstepped its rulemaking authority. Its new bargaining unit rule is directly in conflict with the plain language of the statute. The Final Rule irrebuttably presumes that certain bargaining units are appropriate without allowing adjudication of substantive issues such as the community of interests among employees at any particular facility and consideration of specific facts which might demonstrate that the Board's mandated units for bargaining are not appropriate in every case. Therefore, the Board's Final Rule must be held to be invalid.

This Court has long held that where the language of an act is plain, it must be enforced according to its terms. See *Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain,the sole function of the courts is to enforce it according to its terms."). See also *Consumer Prod. Safety Comm'n v. GTE Sylvana, Inc.*, 447 U.S. 102, 108 (1980) ("[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive"). All that is required for giving statutory language its conclusive effect is that Congress' intent be expressed with sufficient precision in the Act. See *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989) (finding that the inquiry into the meaning of § 506(b) of the Bankruptcy Code should begin and end with the language of the statute itself); see also *INS v. Cardoza Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring) ("Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent"); *Commissioner of Internal Revenue v. Asphalt Prods. Co., Inc.*, 482 U.S. 117, 121 (1987) ("Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided.").

Despite the generally accepted rule of deference to an agency's interpretation of a statute, the Board's discretion and this Court's deference to the Board's interpretation of Section 9(b) "is constrained by [this Court's] obligation to honor the clear meaning of a statute, as revealed by its language, purpose and history". *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The principle of deference to an agency's construction of a statute has no application where the language of the statute is clear. As stated by this Court in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at

issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.

Id. at 842.

As demonstrated by the American Hospital Association in its petition for a writ of certiorari, (see Petition, pp. 14, 17-18), the legislative history of the National Labor Relations Act gives no indication that the language in Section 9(b) has a meaning different from that which is clearly and specifically stated in that section. The Board should not be allowed to circumvent the plain meaning of Section 9(b) by "creating an ambiguity where none exists". See *Escondido Mut. Water Co. v. La Jolla Band of Mission Indians*, 466 U.S. 765, 781 (1984) (rejecting the court of appeals' purported discovery of an ambiguity in Section 4(e) of the Federal Power Act, 16 U.S.C. § 797(e)); *United States v. Turkette*, 452 U.S. 576, 580-81 (1981) (rule of *ejusdem generis* not applicable where no uncertainty exists as to the meaning of a particular clause in a statute).

The Board's interpretation of Section 9(b) should be rejected in light of the plain language of the Act and the Board's prior conflicting interpretations of its statutory obligation to determine a bargaining unit "in each case". Despite its conclusion now that certain bargaining units are *per se* appropriate, the Board has stated many times during adjudicatory proceedings that generalizations as to proper bargaining units are not appropriate. See *Otis Hosp., Inc.*, 219 N.L.R.B. 164 (1975) ("Not all health care institutions may be exactly alike.... Between categories of employees similarly titled, there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly, in functions, responsibilities, procedures, and even expertise."); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980) (holding that the "in each case" requirement of Section 9(b) precluded a *per se* approach to bargaining unit determinations); *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39, 954 (1984) (finding that the diverse nature of the health care industry precludes any generalizations as to the appropriateness of particular bargaining units, the Board stated, "No unit is *per se* appropriate and ... separate representation must be justified upon each factual record....").

This Court has rejected a request for deference to an agency decision where the position of the agency has been inconsistent. See *INS v. Cardoza Fonseca*, 480 U.S. at 446 n.30 ("An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."). The Act's "in each case" language clearly requires consideration of particular facts in each situation to determine the appropriate bargaining unit or at least a rule regulating bargaining unit determinations that provides a meaningful opportunity for an employer in any particular case to demonstrate that the rule should not be applied. The Board's Final Rule should be rejected as contrary to the clear meaning of the statute.

The Board has construed the "in each case" language in another statute, the Postal Reorganization Act, as requiring case by case determinations of bargaining units. In *United States Postal Serv.*, 208 N.L.R.B. 948, 952-53 (1974), the Board followed its traditional community of interests analysis in considering the appropriateness of certain bargaining units involving the Postal Service. The Board was persuaded to analyze the petitions on a case by case basis by the language of the Postal Reorganization Act which states: "The National Labor Relations Board shall decide *in each case* the unit appropriate for collective bargaining in the Postal Service...." 39 U.S.C. § 1202. (emphasis added). There can be no rational reason for a departure from a case by case analysis of health care industry petitions when the language of Section 9(b) also mandates that bargaining unit determinations be made "in each case".

To paraphrase language from then Justice Rehnquist's dissenting opinion in *Steelworkers v. Weber*, 443 U.S. 193 (1979), "by going not merely *beyond*, but directly *against* [Section 9(b)'s] language and legislative history, the [Board] has sown the wind. [Health care employers and ultimately the American public] will face the impossible task of reaping the whirlwind". 443 U.S. at 255 (emphasis in original) (Rehnquist, J., dissenting). The Board's action in adopting its Final Rule "eludes clear statutory language, 'uncontradicted' legislative history, and uniform precedent" and should be invalidated. *Id.* at 222.

C. The Board's Rule Is Inconsistent With The Act Because It Will Deny Fairfax Hospital An Opportunity To Be Heard On The Appropriateness Of An All RN Bargaining Unit And The Particular Conditions Of Employment At Fairfax Hospital

As argued above, Section 9(b) of the Act requires the Board to make a bargaining unit determination in each case. Prior to proposing its Final Rule, the Board had always utilized a case by case adjudicatory approach in determining appropriate bargaining units. Such an approach ensures that each hospital has the opportunity to be heard on the appropriateness of a bargaining unit.

Hospitals which face statutorily imposed obligations with respect to bargaining with representatives of their employees are at least afforded the opportunity to create a factual record as to the appropriateness of alternative units prior to the Board's determination as to the appropriateness of any bargaining unit within their hospitals. Amicus curiae contends that only the Board's case by case representation procedures will provide the appropriate opportunity for health care employers to present evidence relevant to the appropriate bargaining unit question. A case by case determination affords employers the right to be heard in a meaningful manner on important bargaining unit issues and is consistent with the mandate of Section 9(b) of the Act.

In contrast, the Board's Final Rule does not afford a health care employer confronted with a petition for representation the opportunity to argue that only certain bargaining units are appropriate because of the special circumstances of employment in its facility. The Board mandates the appropriateness of certain bargaining units without affording acute care hospitals any meaningful opportunity to be heard on the bargaining unit issue. The Board's Final Rule creates a conclusive presumption that only certain units are appropriate. As stated by the Board during its rulemaking proceeding:

We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers.... Though an "extraordinary circumstances" exception has been in-

cluded, it is anticipated that the exception will be little used and limited to truly extraordinary situations....

NPR I, 52 Fed. Reg. 25,142 (1987).

The Board's decision to eschew a rebuttable presumption in favor of a conclusive or irrebuttable presumption creates a rule which is inconsistent with the mandate of Section 9(b) to make bargaining unit determinations "in each case." That language mandates consideration of specific facts in each case. Unless interested parties are afforded an opportunity to rebut the presumptions created by the Board's Final Rule, the Board's rulemaking is contrary to the Act and is thus invalid. See *Big Y. Foods v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981) (stating that Section 9(b) would invalidate a conclusive presumption because "a conclusive presumption precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees"). The Board has discretion to use rulemaking but only if it is consistent with the Act. See *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 501 (1978); see also Note, *NLRB Guidelines For Determining Health Care Industry Bargaining Units: Judicial Acceptance or Back to the Drawing Board*, 78 Ky. L.J. 143, 158-61 (1989).

The Board's "extraordinary circumstances" exception will not provide an adequate opportunity for individual hospitals to raise issues regarding the appropriateness of any of the mandated bargaining units in their facility. As mentioned, the Board's extraordinary circumstances exception is extremely narrow. In particular, the Board will not consider increased functional integration between employees, or a high degree of work contacts between employees as an extraordinary circumstance meriting relief from the Rule. Similarly, the increased use of team care and cross-training of health care professionals which is occurring with increasing frequency in modern acute care hospitals will not be entertained by the Board as an extraordinary circumstance. Differences in the sizes of acute care hospitals, the variety of services offered by each institution and differences in staffing pattern among such facilities will also not be given weight as extraordinary circumstances warranting relief from the Rule. 53 Fed. Reg. 33,932-33 (1988).

It becomes apparent, therefore, that the Board's Rule, even with its "extraordinary circumstances" exception, ignores significant differences among acute care hospitals in the nation and effectively denies hospitals employing an integrated health care team the opportunity to demonstrate that eight different bargaining units would result in a significant disruption in the delivery of health care at their institution. Application of the Rule will prevent Fairfax Hospital from arguing the appropriateness of alternative bargaining units in response to the pending petition by the DCNA. The very factors that make Fairfax Hospital unique, i.e., the integration of health care professionals and the coordinated delivery of health care with the resulting confluence of common interests between professionals at the facility, will never be explored if the Board's new Rule is allowed to be implemented and applied to the pending petition.

The petition for an all RN unit at Fairfax Hospital will undoubtedly be approved by the Regional Director for the NLRB without a specific analysis of employment conditions at Fairfax Hospital. If the union is successful in convincing registered nurses to vote for representation, Fairfax Hospital will be faced with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at Fairfax Hospital. The result will be a fragmentation of the work force, with some professionals working under work rules governed by the collective bargaining agreement and others working under the policies of the Fairfax Hospital System.

Fairfax Hospital has instituted a team approach to medical care within the Hospital and it has integrated the services of its professionals in implementing this approach. The Board's Final Rule would set registered nurses apart in an artificially created labor relations unit that will undoubtedly impede the coordinated delivery of health care envisioned by the Fairfax Hospital organization. Work rules developed out of the negotiations between the union and the Hospital may also conflict with the coordinated delivery of services currently utilized by the Hospital. Ultimately, if the Board's *per se* Rule is approved, the Hospital may have to deal with eight separate units of employees, all working under separate contracts with separate work rules, separate salary structures, and separate benefit plans, all of

which will be monitored and patrolled by cadres of union stewards. The Fairfax Hospital System believes that such a proliferation of units is an unnecessary consequence of the union organizing which is now occurring at Fairfax Hospital. The Fairfax Hospital System believes that its integrated organizational structure merits consideration of other possible bargaining units by which the desire for union representation, such as it may exist, can be accommodated in a coordinated and reasonable manner.

The Fairfax Hospital System urges the Court to consider whether the Board's Final Rule gives Fairfax Hospital any realistic opportunity to demonstrate that its coordinated approach to health care delivery warrants consideration of bargaining units other than the eight rigid groupings set forth in the Final Rule. For example, registered nurses at Fairfax Hospital are not set apart into a separate nursing division as was the case in the *Frederick Memorial Hosp.* decision. Registered nurses ("RNs") working at Fairfax Hospital regularly interact with other health care professionals. The organizational structure of the Hospital promotes integration between health care professionals rather than isolation of groups of professionals.

The Hospital also has mechanisms in effect for increasing the integration between professionals and the delivery of coordinated health care services to its patients. For example, delivery of emergency care is very much a team effort with nurses, physicians and x-ray technicians treating the same patient. Fairfax Hospital utilizes collaborative practice committees to enhance the effectiveness of treatment through planning and exchange of professional ideas. More complex patient care questions are the subject of Grand Rounds where interdisciplinary groups of professionals meet and discuss the more challenging patients under their care. The participants in Grand Rounds may include physicians, RNs, social workers, dieticians and other allied health professionals. During these sessions, a patient's illness is studied in detail. Nutritional needs of the patient and post-discharge concerns are also topics of review among relevant health care professionals.

This team concept for patient care is repeated in other areas of Fairfax Hospital. For example, the Hospital uses a special team to facilitate treatment of pediatric patients. The team consists of a child

life specialist, an art therapist, and a social worker who interact with RNs in Pediatrics. Creative therapists work closely with psychiatric nurses at the Hospital to enhance recovery of psychiatric patients. Physicists and dosimetrists in the Medical Physics Department provide necessary support to the Radiation Oncology Department which utilizes both RNs and radiation therapists on its staff. Physicists calibrate the equipment which the Radiation Oncology Department uses while dosimetrists measure radiation doses which the radiation therapists and RNs administer and monitor. Pharmacists are assigned to nursing units in various satellite pharmacies to increase coordination and delivery time of medicine to the Hospital's patients. RNs work with pharmacists and dieticians on nutrition support teams to assist the recovery of patients. Finally, discharge planning is also a team effort with social workers, physicians and RNs working together to coordinate the patient's return to the community.

Registered nurses at Fairfax Hospital are also present in various specialty areas where they work closely with allied professionals. For example, RNs work with radiology technologists in the Hospital's surgery center. Social workers who are assigned to patients in Cardiac Therapy interface with RNs and exercise physiologists. Physical therapists are consulted by RNs regarding the types of exercises most conducive to recovery of cardiac patients. The Infection Control Unit of Quality Resource Services is comprised of both RNs and medical technologists who serve as epidemiologists. Infection Control personnel interact with other allied health professionals at the Hospital during investigations of incidents of secondary infection at the Hospital. In addition, they provide instruction and education on infection control to coalitions of health care personnel. The Health Source Department is comprised of dieticians as well as RNs who provide community education in Lamaze techniques and nutrition. RNs and sonographers work together in the Women's and Children's Services Division. The Blood Donor Center utilizes both medical technologists and RNs in operating the Center. In point of fact, medical technologists and RNs both participate in blood drives as needed, recruit, interview, schedule and instruct blood donors, and draw blood.

Registered nurses working with other professionals in various departments share common supervision. The immediate supervisor in the department is often an allied health professional who is a

non-RN. For instance, the Director of Cardiovascular Services, a cardiovascular technologist, supervises RNs and cardiovascular technologists. The Radiation Therapy Director, a radiation therapist, supervises RNs and radiation therapists within the department. The head of the Blood Donor Center, a medical technologist, supervises RNs and medical technologists. The Director of Social Work, a social worker, supervises both RNs and social workers within that department. The Director of Radiology, a cardiovascular technologist, supervises both RNs and x-ray technologists.

The Board's Final Rule also ignores other factors at Fairfax Hospital which would undoubtedly weigh in favor of an alternative to the bargaining unit of registered nurses mandated by the Rule. For example, RNs and other allied health professionals at the hospital participate in the same benefit plans, receive comparable salaries, overtime and bonus pay. RNs and other allied health professionals all receive shift differential and weekend alternative premium. On call pay has been extended to RNs and other allied health professionals. All employees at Fairfax Hospital are also subject to identical personnel policies.

Fairfax Hospital's team approach to patient care clearly will be disrupted by the *per se* application of the Board's Final Rule. The Final Rule forces professionals working on the same hospital team into separate units for bargaining. The Rule also increases the likelihood that these professionals will be represented by different unions. The hospital's team concept could be threatened by jurisdictional disputes over which work will be performed by which union. Conflicting work rules regarding hours of work, overtime and other working conditions are likely to destroy the cohesion of the hospital's team approach to patient care. Ultimately, patient care may be impaired by the conflict between union members, thereby creating the very situation which Congress attempted to avert in drafting the Health Care Amendments Act and instructing the NLRB to avoid proliferation.

D. The Board's Rule Is Arbitrary And Capricious Insofar As It Ignores The Differing Sizes, Locations And Operations Of Other Hospitals Within The Fairfax Hospital System

The dilemma for the Fairfax Hospital System is likewise ominous if the Board's *per se* Rule is allowed to have application to all of the hospitals within the System without an individual analysis of the merits of any particular bargaining unit at each hospital. The Board's Final Rule presents the potential for 32 different bargaining units within the Fairfax Hospital System. This is true even though the hospitals vary in size from 4,600 employees at Fairfax Hospital to only 440 employees at Jefferson Hospital. Although there are 656 beds at Fairfax Hospital, there are only 120 beds at Jefferson Hospital. Fair Oaks Hospital is also a smaller facility with only 160 beds. Fairfax Hospital employs over 1400 registered nurses whereas Jefferson Hospital has 136 registered nurses. Other allied health professionals at Fairfax Hospital number approximately 590 while there are approximately 66 allied health professionals at Jefferson Hospital.

Patient care services vary from hospital to hospital. The range of services offered obviously is much more complex and varied at Fairfax Hospital than can be achieved at Jefferson Hospital. The operating budget at Fairfax Hospital is almost ten times greater than that of Jefferson Hospital. Even assuming an all RN unit is appropriate at Fairfax Hospital, a similar fragmentation of the professional work force at Jefferson Hospital would not necessarily be appropriate. The Board's Rule mandates such fragmentation, nevertheless.

The same mechanisms that are in effect at Fairfax Hospital for integrating health care professionals are present at the smaller hospitals within the Fairfax Hospital System. These hospitals also utilize team concepts for delivery of health care. For example, within the Cardiology Department at Jefferson Hospital, RNs perform many of the same duties as cardiovascular technicians. Mount Vernon Hospital employs a "Surgical Suite" which uses an interdisciplinary approach to surgery with RNs, surgical technicians, physicians, and physicians' assistants working together to deliver quality health care. Laboratory technicians, radiology technicians, RNs, social workers and physicians work together in Emergency Services at Mount Vernon

Hospital. Certain nursing units at Mount Vernon Hospital work closely with physical therapists, occupational therapists, and speech pathologists from Physical Medicine and Rehabilitation Services to coordinate treatment of patients referred to the Physical, Medicine and Rehabilitation Department.

Registered nurses and allied health professionals also work in service departments where they share common supervision. The Assistant Administrator for Nursing supervises respiratory therapists at Jefferson Hospital. Diabetes Management at Jefferson Hospital is overseen by an RN whose duties include coordinating the activities of clinical dietitians. The Director of Radiology at Fair Oaks Hospital supervises RNs and radiology technicians within the Radiology Department. The Cardiac Catheterization Laboratory at Fair Oaks Hospital utilizes RNs and cardiovascular technicians. The laboratory's supervisor is a cardiovascular technician who reports to a Patient Care Director who is a registered nurse.

The Fairfax Hospital System applies the same benefit plans, personnel policies and salary scales to all employees in the System. See App., pp. 5a-7a. All professionals are analyzed using a Job Analysis Questionnaire and each is then assigned to a grade within a designated range. This salary analysis procedure is done at each of the hospitals in the System and the results are coordinated and administered by personnel at System headquarters. The result is a uniform salary structure which produces comparable pay within the System for all professionals and common interests in wages and benefits between RNs and other allied health professionals at each hospital. The cost to the Fairfax Hospital System of restructuring its benefit plans, its salary scales, and its personnel policies to accommodate 32 different bargaining units would be enormous.

The Board's Final Rule is arbitrary and capricious in that it fails to recognize the differences between the various hospitals within the Fairfax Hospital System and because it prevents any particular hospital from arguing the reasonableness of a lesser number of bargaining units than that which is mandated by the Board's Final Rule. The potential problems and disruption which would likely be experienced within the Fairfax Hospital System will reoccur within other hospital systems unless the Court overturns the Seventh Circuit's decision and

reinstates the injunction ordered by the district court. A decision overturning the Board's Final Rule is needed now before costs and disruption begin escalating for the Fairfax Hospital System and other health care institutions in this country.

IV. CONCLUSION

For all the foregoing reasons and for the reasons stated in the brief of the American Hospital Association, the decision of the Seventh Circuit should be reversed.

Respectfully submitted,

By: _____

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The Fairfax Hospital System

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APPENDIX

1a

Mayer, Brown and Platt

October 17, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: American Hospital Association v. NLRB

Dear Mr. Lusky:

On behalf of the American Hospital Association, I hereby consent to the filing of a brief *amicus curiae* by the Fairfax Hospital System in the above-referenced case.

Sincerely,

/s/ James D. Holzhauer

2a

**U.S. Department of Justice
Office of the Solicitor General**

October 16, 1990

Paul M. Lusky
Counsel
Kruchko & Fries
Counsels at Law
Suite 202
7929 Westpark Drive
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*
No. 90-97

Dear Mr. Lusky:

In response to your letter of October 11, 1990, I hereby consent to the filing in the above-captioned case of an *amicus curiae* brief on behalf of the Fairfax Hospital System.

Sincerely,

/s/ Kenneth W. Starr
Solicitor General

3a

Dickstein, Shapiro and Morin

October 23, 1990

Paul M. Lusky, Esquire
Kruchko & Fries
7929 Westpark Drive
Suite 202
McLean, Virginia 22102

RE: *American Hospital Association v. N.L.R.B.*, et al.
No. 90-97

Dear Mr. Lusky:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of Fairfax Hospital System.

Sincerely,

/s/ Woody N. Peterson

4a

**American Federation of Labor and
Congress of Industrial Organizations**

October 16, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB, et al.*
(Supreme Court No. 90-97)

Dear Mr. Lusky:

The American Federation of Labor and Congress of Industrial Organizations hereby consents to the timely filing of an *amicus curiae* brief in support of the petitioner in the above-referenced matter on behalf of the Fairfax Hospital System.

Sincerely yours,

/s/ David Silberman

5a

EMPLOYEE BENEFIT SUMMARY

EMPLOYEE BENEFIT	APPLICABLE TO	
	Regular Full-Time	Regular Part-Time
HEALTH & WELFARE		
SHARED*CARE:		
FREE to full-time employee	Yes*	Yes*
Kaiser-Permanente Health Plan (HMO)	Yes*	Yes*
Group Health Association (HMO)	Yes*	Yes*
Dental Insurance:		
FREE to full-time employee	Yes*	Yes*
Life Insurance with AD&D:		
FREE to employee	Yes	Yes*
Supplemental Life Insurance for Employees and/or Dependents:		
Purchased thru payroll deduction	Yes	Yes**
Disability Income Insurance:		
FREE to employee	Yes	No
Retirement Program: FREE to employee working 1000 hours or more/yr		
Yes	Yes	Yes
Social Security (employee contributions matched)		
Yes	Yes	Yes
Worker's Compensation	Yes	Yes
Unemployment Insurance	Yes	Yes
Employee Health Program	Yes	Yes

*For full-time employees some benefits may require contributions such as family plan for hospitalization and dental insurance, extra cost for HMO or IPA plans and optional additional life insurance. Part-time employees (at least 20 hours per week) pay full premium but at group rates.

**Applicable to part-time employees budgeted 16 or more hours per week.

EMPLOYEE BENEFIT SUMMARY (continued)**PAID TIME OFF (Employees budgeted to work 15 hours or less per week are not eligible)**

Paid Vacations: 10 days increasing to 20 days over 10 years	Yes	Yes**
Paid Sick Leave: up to 12 days	Yes	Yes**
Paid Holidays: 7 days	Yes	Yes**
Paid Personal Days Off: 3 days	Yes	Yes**
Paid Time Off Upon Death of Family Member: up to 3 days	Yes	Yes

MISCELLANEOUS SERVICES

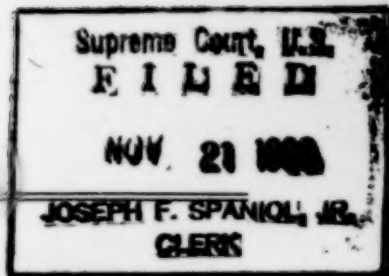
CONCERN: Employee Assistance Program	Yes	Yes
Tuition Assistance Program	Yes	Yes**
Shift Differential & Weekend Differential Pmts	Yes	Yes
Grievance Procedure	Yes	Yes
Employee Credit Union	Yes	Yes
Employee Recreation Programs	Yes	Yes
FREE Employee Parking	Yes	Yes
FREE Uniforms & Laundry (certain departments)	Yes	Yes
Awards for Length of Service	Yes	Yes
Pharmacy Purchases (prescriptions)	Yes	Yes
Thanksgiving & Christmas Dinners: FREE to employee	Yes	Yes
Cafeteria: Lower Prices	Yes	Yes
Group Tax Shelter Annuity Program	Yes	Yes
Purchase U.S. Savings Bonds by Payroll Deduction	Yes	Yes
Pre-Retirement Counseling	Yes	Yes

**Applicable to part-time employees budgeted 16 or more hours per week.

FAIRFAX HOSPITAL SYSTEM SALARY RANGES

Nursing range	\$13.70 - \$21.00
PTs, OTs, SPs	\$12.85 - \$19.66
Respiratory therapists	\$12.84 - \$19.63
Advanced pulmonary tech	\$12.84 - \$19.63
Ultrasonographer	\$12.70 - \$19.47
Special procedures tech	\$12.70 - \$19.43
Radiation Oncology tech	\$12.44 - \$19.04
Pharmacists	\$12.14 - \$24.75
Social workers	\$12.14 - \$18.57
Nuclear medical techs	\$11.47 - \$17.59
Dieticians	\$11.29 - \$17.27
Medical techs	\$10.86 - \$16.67

(14)
No. 90-97



In The
Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,
vs.
NATIONAL LABOR RELATIONS BOARD, ET AL.,
Respondents.

**ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT**

**BRIEF OF AMICUS CURIAE SUPPORTING
PETITIONER AMERICAN HOSPITAL
ASSOCIATION**

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INTRODUCTORY STATEMENT

After more than 50 years of determining appropriate groupings of similarly-situated employees to be collectively represented as "bargaining units" on a case-by-case basis, the National Labor Relations Board ("the Board") announced in July 1987¹ that it would exercise its seldom-used quasi-legislative Administrative Procedure Act

¹The initial notice of proposed rulemaking and notice of hearing appears at 52 Fed. Reg. 25,142 (1987) [hereinafter cited as *NPR I*]. The Board's second notice and revised proposed rule appears at 53 Fed. Reg. 33,900 (1988) [hereinafter cited as *NPR II*]. The Board's final action, entitled "Collective-Bargaining Units in the Health Care Industry; Final Rule," appears at 54 Fed. Reg. 16,336 (1989) (codified at 29 C.F.R. § 103.30(a)-(g) (1990)) [hereinafter cited as *Final Rule*].

("APA") rulemaking authority² to establish fixed bargaining units in the health care industry. Ultimately, the Board promulgated a rule which recognizes as appropriate in all acute care hospitals, regardless of differences in their size or operations, eight separate bargaining units. Ironically, the Board targeted the industry where it has the least experience³ with bargaining unit determinations for its first experiment in making substantive law by quasi-legislative rulemaking. Even more ironically, the Board also targeted for its rigid *per se* approach a diverse and rapidly changing industry very much in need of flexible rules.

The Board's quasi-legislative rulemaking is subject to judicial review under the APA. As the discussion below shows, the final rule devised by the Board is arbitrary, capricious, an abuse of discretion and otherwise not in accordance with the law.

INTEREST OF AMICUS CURIAE

The California Association of Hospitals and Health Systems ("CAHHS") and the Hospital Council of Southern California ("HCSC") are non-profit associations whose members consist of hospitals and other health care institutions. CAHHS represents over 500 hospitals throughout the State of California. It is the largest state

²Section 6 of the National Labor Relations Act provides: "The Board shall have the authority from time to time to make, amend, and rescind, in the manner prescribed by Subchapter II of chapter 5 of Title 5 [the APA], such rules and regulations as may be necessary to carry out the provisions of this subchapter." 29 U.S.C.A. § 156 (West 1973).

³The Board has only exercised authority over non-profit health care institutions since 1974. See Pub. L. No. 93-360, 88 Stat. 395 (1974).

hospital association in the nation. HCSC represents over 200 hospitals in Southern California.

Most members of CAHHS and HCSC are acute care hospitals⁴ subject to the Board's bargaining unit rule challenged in this action. If the rule is implemented, the acute care hospitals who are members of CAHHS and HCSC will face potentially catastrophic disruptions of patient care and serious interference with their capacity to flexibly and efficiently deliver health care services. CAHHS and HCSC submit this brief in an effort to protect the vital interests of their members in avoiding the serious problems associated with bargaining unit proliferation which were foreseen by Congress in 1974 and, until promulgation of the challenged rule, were prevented by decisions of the federal courts sharply limiting the number of acceptable bargaining units in the health care industry.

SUMMARY OF ARGUMENT

By promulgating a *per se* rule recognizing eight bargaining units as appropriate in all acute care hospitals, the Board has violated the National Labor Relations Act ("NLRA" or "the Act"). First, it has deprived such institutions of the right conferred by Section 9(b) of the Act to establish bargaining units according to their own circumstances "in each case." Additionally, it has violated the congressional admonition to avoid proliferation of bargaining units in health care institutions.

Moreover, an examination of the rulemaking record shows that the Board went through tortuous gyrations to justify its establishment of eight mandatory units and its

⁴"Acute care hospital" is defined for purposes of the challenged rule at 29 C.F.R. § 103.30(f)(2) (1990).

abandonment of case-by-case adjudication. To achieve this result, the Board (1) reversed its strongly held conviction, announced just seven years earlier, that both statutory requirements and policy reasons preclude a *per se* approach to bargaining unit determinations; (2) labeled as substantially uniform and therefore subject to a *per se* approach an industry which, just three years earlier, it considered too diverse for generalizations; (3) scuttled all previously applied standards in favor of an "empirical" approach with no discernable standard; (4) dismissed as inconsequential or irrelevant factors which it previously had considered dispositive, and vice versa; (5) attempted to circumvent the legislative history of the 1974 health care amendments to the Act by attacking Congress' conclusions with questionable statistics; and (6) ultimately established bargaining unit configurations based on the perceived desires of employees and labor organizations, criteria which may not lawfully be given controlling effect. Accordingly, the Board's promulgation of the eight bargaining unit rule was arbitrary, capricious, an abuse of discretion and not otherwise in accordance with law.

ARGUMENT

I. Historical Background

A. The 1974 Amendments

In 1974, the NLRA was amended to extend coverage to non-profit hospitals. Pub. L. No. 93-360, 88 Stat. 395 (1974). The dominant theme in the 1974 amendments and their legislative history was Congress' intent to minimize

strikes and labor disputes in the health care industry and the accompanying disruption of patient care.⁵

Congress' intent to minimize labor disruptions in the health care industry was evident in its consideration of appropriate bargaining units. During the hearings leading to passage of the 1974 amendments, the concern repeatedly was expressed that unit fragmentation in health care institutions would increase labor disputes and adversely affect patient care. See 1 C. MORRIS, *THE DEVELOPING LABOR LAW* 437 & n.130 (2d ed. 1983) (citing Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 93d Cong., 2d Sess., *Legislative History of Non-Profit Hospitals under the National Labor Relations Act* (1974)). Congress specifically directed in the Senate and House committee reports that "[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry." *Id.* (citing S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974), and H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 7 (1974)). The committee reports cited with approval prior Board cases reflecting a trend toward broader units in the health care industry. *Id.* Co-sponsors of the 1974 amendments emphasized in debates that unit proliferation in the health care industry would lead to jurisdictional disputes, work stoppages, wage whipsawing, and higher medical costs to the public. 120 Cong.

⁵For example, the 1974 amendments provide special deadlines for filing notices of termination and modification of health care collective bargaining agreements prior to expiration and for special advance notification to the Federal Mediation and Conciliation Service of the intent to strike, picket, or engage in other concerted refusal to work. See NLRA §§ 8(d)(A)-(C) and 8(g), 29 U.S.C.A. §§ 158(d)(A)-(C) and 158(g) (West 1973 & Supp. 1990).

Rec. 12,944-45, 13,559, 22,949 (1974) (statements of Sen. Taft and Rep. Ashbrook).

B. The Board's Post-Amendments Nonacquiescence

In the years since the 1974 amendments, there has been a protracted struggle between the Board and the courts resulting from the Board's tendency to ignore Congress' nonproliferation directive and the courts' almost uniform insistence on adherence to the legislative intent.⁶ The Courts of Appeals repeatedly have rejected both (1) the Board's attempts to make inflexible, *per se* predeterminations that certain separate bargaining units (chiefly units of registered nurses and skilled maintenance workers) are appropriate, and (2) the Board's failure to adhere to the congressional directive against unit proliferation. The Board has more than proved the validity of Congress' concern that, if left to its own devices, it would ignore the public's special interest in uninterrupted and low-cost delivery of health care services, and would find the same

⁶See *NLRB v. Walker City Medical Center, Inc.*, 722 F.2d 1535 (11th Cir. 1984); *Watsonwan Memorial Hospital, Inc. v. NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191 (4th Cir. 1982); *Presbyterian St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. Mercy Hospital Ass'n*, 606 F.2d 22 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB v. Sweetwater Hospital Ass'n*, 604 F.2d 454 (6th Cir. 1979); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979). One isolated decision of the District of Columbia Circuit found the nonproliferation statements in the legislative history of the 1974 amendments to be of no legal effect. See *Electrical Workers IBEW Local 474 v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987). The decision of the District of Columbia Circuit is contrary to the decisional law of every other circuit except the First and Fifth Circuits, which have not yet ruled on the issue.

type of bargaining units appropriate in a health care facility as an industrial plant. See *Allegheny General Hospital*, 239 N.L.R.B. 872, 883 (1978) (Penello dissenting), *enforcement denied*, 608 F.2d 965 (3d Cir. 1979).

The great majority of decisions reversing the Board's bargaining unit determinations involve rejections of separate bargaining units for registered nurses and skilled maintenance employees.⁷ Shortly after the 1974 amendments, the Board established a presumption that units of registered nurses were appropriate, and then proceeded to treat the presumption as irrebuttable. The irrebuttable presumption promptly was rejected by the courts. See *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979). In *St. Francis of Lynwood*, the Ninth Circuit ruled that the congressional directive against unit proliferation required a "disparity of interests" test, focusing on whether differences in interests among employees precluded representation in the same collective bargaining unit. Under the disparity of interests test, all professional employees would be included in the same unit unless the disparity of interests was great enough to justify exclusion.⁸

⁷Ironically, the rule which is challenged here makes mandatory, among the eight recognized units, separate units of registered nurses and skilled maintenance employees. See *infra* note 13.

⁸In other industries, in order to place employees with similar interests together in the same unit, the Board has applied a "community of interests" test by examining such factors as similar occupations, common supervision, common job duties and conditions of employment, interchange of employees, day-to-day contact among employees, and other issues which affect the workplace environment. In any given workplace, there are likely to be multiple overlapping units which could be found appropriate under the community of interests standard. See generally 1 C. MORRIS, *THE DEVELOPING LABOR LAW* 416-17 (2d ed. 1983).

The Board did not acquiesce in the *St. Francis of Lynwood* decision. It did revert to a procedure wherein it would decide appropriate bargaining units based on the evidence developed in each case. *Newton-Wellesley Hospital*, 250 N.L.R.B. 409 (1980). It continued, however, to decide health care bargaining unit cases based on the "community of interests" standard used for other industries, and asserted that the Ninth Circuit's disparity of interests test was "encompassed" within the community of interests test. *Id.* at 411-12. Two years later, the Ninth Circuit rejected the Board's argument, reaffirmed its instructions to the Board, and again denied enforcement of Board certification of an all registered nurse unit. *NLRB v. HMO Int'l*, 678 F.2d 806, 812 (9th Cir. 1982).

The Fourth Circuit joined the Ninth Circuit by rejecting a registered nurse unit and the Board's application of the community of interests test in *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191 (4th Cir. 1982). The Tenth Circuit also rejected a registered nurse unit and joined the Ninth Circuit in adopting the disparity of interests test. *Presbyterian-St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981).⁹

The courts also repeatedly have rejected the Board's attempts to approve separate bargaining units for skilled maintenance employees. See *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 970 (3d Cir. 1979); *NLRB v. Mercy Hospital Ass'n*, 606 F.2d 22 (2d

⁹Three other circuits have insisted that the Board must clearly apply the congressional admonition against undue unit proliferation. *NLRB v. Walker City Medical Center, Inc.*, 722 F.2d 1535 (11th Cir. 1984); *Watsonwan Memorial Hospital, Inc. v. NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB v. Sweetwater Hospital Ass'n*, 604 F.2d 454 (6th Cir. 1979).

Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 216 (7th Cir. 1978).

Meanwhile, the Board itself waffled over the issue of appropriate bargaining units in the health care industry and the community of interests versus the disparity of interests standard. In *St. Francis Hospital*, 265 N.L.R.B. 1025 (1982) [hereinafter cited as *St. Francis I*], a divided Board adhered to the position that the community of interests and disparity of interests tests are essentially the same. In *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) [hereinafter cited as *St. Francis II*], finally agreeing to adhere to the congressional admonition against bargaining unit proliferation, another divided Board vacated *St. Francis I* and adopted the disparity of interests standard. Using the disparity standard in that case, it denied certification of a separate unit of maintenance employees. Using the disparity standard in subsequent cases involving petitions for registered nurse units, the Board uniformly held such units to be inappropriate. See *Keokuk Area Hospital*, 278 N.L.R.B. 242 (1986); *North Arundel Hospital Ass'n*, 279 N.L.R.B. 311 (1986); *Middletown Hospital Ass'n*, 282 N.L.R.B. 541 (1986); *St. Vincent Hospital and Health Center*, 285 N.L.R.B. 365 (1987).

C. The Board's Section 6 Rulemaking

In 1987, apparently frustrated by the rejection of its disparity of interests approach in an aberrant decision of the District of Columbia Circuit,¹⁰ the Board decided to

¹⁰*Electrical Workers IBEW Local 474 v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987). See *supra* note 6 and accompanying text. On remand, the Board expressed its strong disagreement with the District of Colum-

(Continued . . .)

engage in rulemaking pursuant to Section 6 of the Act, 29 U.S.C.A. § 156 (West 1973). The Board elected this approach instead of petitioning for Supreme Court review.¹¹

In July 1987, the Board issued its first notice of proposed rulemaking (*NPR I*). The Board proposed a rule providing that in health care institutions, absent undefined "extraordinary circumstances," only bargaining units spelled out in the rule would be recognized by the Board. The proposed rule governed acute care hospitals and nursing homes; bargaining units in other types of health care institutions would continue to be determined by adjudication on a case-by-case basis. In *NPR I*, the Board proposed to recognize six bargaining units in large acute care hospitals (more than 100 patient beds) and four bargaining units in small acute care hospitals. See

¹⁰(... Continued)

bia Circuit's interpretation and continued to assert its adherence to the disparity of interests test as an exercise of its "reasoned discretion," whether or not the congressional admonition was a binding directive. *St. Francis Hospital*, 286 N.L.R.B. 1305, 1306 (1987) [hereinafter cited as *St. Francis III*]. See also *St. Vincent Hospital and Health Center*, 285 N.L.R.B. at 367-368.

¹¹The decision to engage in rulemaking did not have the concurrence of the full Board. Member Johansen maintained throughout the process that establishing appropriate bargaining units by APA rulemaking contravenes the Board's obligation to decide such issues on a case-by-case basis pursuant to Section 9(b) of the Act, 29 U.S.C. § 159(b), and that the appropriate method for resolving the conflicting judicial decisions is to "submit these questions to the Supreme Court." *NPR II*, 53 Fed. Reg. at 33,935. See also *Final Rule*, 54 Fed. Reg. at 16,347.

NPR I, 52 Fed. Reg. 25,142.¹² Notwithstanding its recognition of units which had been found inappropriate in adjudicated cases applying the disparity of interests standard (e.g., registered nurse units), the Board purported in *NPR I* to continue applying that standard. See *NPR I*, 52 Fed. Reg. at 25,146.

On September 1, 1988, the Board issued a second proposed rule (*NPR II*) which departed substantially from the original proposed rule. The second proposed rule eliminated the distinction between small and large acute care hospitals and specified eight units for all acute care hospitals regardless of their size or the nature of their operations.¹³ See *NPR II*, 53 Fed. Reg. 33,900. In making this proposal, the Board asserted that it was abandoning all previous "doctrinal formulations," including the community of interests and disparity of interests standards, in favor of an "empirical" approach. See *NPR II*, 53 Fed. Reg. at 33,904-906.

On April 18, 1989, the Board issued the final rule, which is codified at 29 C.F.R. § 103.30(a)-(g) (1990). The final rule establishes eight¹⁴ mandatory bargaining units for acute care hospitals regardless of size or operations

¹²For large hospitals, the mandatory units were: (1) registered nurses, (2) physicians, (3) all other professionals, (4) all technical employees, (5) service, maintenance and clerical employees, and (6) guards. For small hospitals the mandatory units were: (1) all professionals, (2) all technical employees, (3) all service, maintenance and clerical employees, and (4) all guards. *NPR I*, 52 Fed. Reg. 25,142.

¹³The eight units for all sizes of acute care hospitals were: (1) registered nurses, (2) physicians, (3) all other professionals, (4) all technical employees, (5) skilled maintenance employees, (6) business office clericals, (7) guards, (8) all other nonprofessionals. *NPR II*, 53 Fed. Reg. 33,900.

¹⁴The eight units in the final rule are the same eight units listed at note 13, *supra*.

and exempts only hospitals that are primarily nursing homes, psychiatric hospitals, or rehabilitation hospitals. The rule permits "various combinations" of the eight units "if sought by labor organizations." Otherwise, the final rule provides for deviations from the eight units only in "extraordinary circumstances" and circumstances where there are existing non-conforming units. The rule itself does not define "extraordinary circumstances" other than to state that units of five or fewer employees shall constitute an "extraordinary circumstance." However, in the commentary accompanying the rule, it is clear that except for this five-employee threshold, acute care hospitals are effectively foreclosed from asserting that any extraordinary circumstances exist.¹⁵

II. The Rule Violates The National Labor Relations Act

In reviewing rulemaking under the APA the courts will "hold unlawful and set aside agency action . . . found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C.A. § 706(2) (A) (West 1977) (emphasis added). Furthermore, on review, a court must "decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of the agency action." 5 U.S.C.A. § 706 (West 1977). The

¹⁵In *NPR II*, the Board defined the scope of the "extraordinary circumstances" exception by setting forth what would not qualify. After listing six specific factors that the Board deemed too "ordinary" to qualify, it stated that it would not consider any evidence within "the range of circumstances revealed at the [rulemaking] hearings and known to the Board from more than 13 years of adjudicating cases in this field . . ." *NPR II*, 53 Fed. Reg. at 33,933. In the commentary accompanying the final rule, the Board reaffirmed this intent. *Final Rule*, 54 Fed. Reg. at 16,345.

Board's action here is not in accordance with the National Labor Relations Act.

A. The Rule's Establishment Of Mandatory Bargaining Units On An Industry-Wide Basis Violates Section 9(b) Of The Act

Section 9(b) of the Act, 29 U.S.C.A. 159(b) (West 1977), requires that the Board determine the unit or units appropriate for collective bargaining "in each case." The petition for certiorari filed by the American Hospital Association ("AHA") contains a detailed analysis of Section 9(b) and its legislative history. See AHA's *Petition for Writ of Certiorari*, at 12-21 [hereinafter cited as *AHA Petition*]. Those arguments need not be repeated here.

It should be noted, however, that AHA's interpretation of Section 9(b) finds further support in the continued reluctance of Congress to establish *per se* appropriate bargaining units. Since adopting the "in each case" language in 1935, Congress twice has rejected legislation which would have interfered with case-by-case unit determinations. When Congress deliberated over the 1974 amendments, it rejected S. 2292, introduced by Senator Taft, which would have specified four fixed bargaining units in the health care industry. See *St. Francis of Lynwood*, 601 F.2d at 411. In 1978, Congress considered and failed to pass S. 2467, which would have required the Board to embrace rulemaking in several areas, including an elaboration of appropriate bargaining units. See *NPR I*, 52 Fed. Reg. at 25,144.

Moreover, on a number of occasions prior to initiating the current rulemaking, the Board has expressed, in the strongest possible terms, that unit determinations must be carefully tailored to the facts of each individual case.

In so doing, it has relied both on its interpretation of Section 9(b) and on policy considerations.

For example, in *Kalamazoo Paper Box Corp.*, 136 N.L.R.B. 134 (1962), the Board said:

Because the scope of the unit is basic to and permeates the whole of the collective-bargaining relationship, each unit determination, in order to further effective expression of the statutory purposes, must have a direct relevancy to the circumstances within which collective bargaining is to take place. For, if the unit determination fails to relate to the factual situation with which the parties must deal, efficient and stable collective bargaining is undermined rather than fostered.

136 N.L.R.B. at 137. The Board went on to state that an erroneous decision with respect to the scope of a bargaining unit:

[w]ould result in creating a fictional mold within which the parties would be required to force their bargaining relationship. Such a determination could only create a state of chaos rather than foster stable collective bargaining and could hardly be said to "assure to employees the fullest freedom in exercising the rights guaranteed by this Act" as contemplated by Section 9(b).

136 N.L.R.B. at 139-40.

Subsequently, in *Newton-Wellesley Hospital*, 250 N.L.R.B. 409 (1980), the Board specifically acknowledged that a *per se* approach to bargaining units in the health care industry would violate Section 9(b). Agreeing in this regard with the decision of the Ninth Circuit in *St. Francis of Lynwood*, the Board stated:

We have concluded that so much of the Board's *St. Francis* Decision as may be read to establish an

irrebuttable presumption of the appropriateness of registered nurse units in all cases, without regard to particular circumstances, should be disavowed. Such a *per se* approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide "in each case" whether the requested unit is appropriate. Moreover, as the court [in *St. Francis of Lynwood*] pointed out, the legislative history of the 1974 health care amendments to the Act requires the Board to give due consideration to avoiding an unwarranted fragmentation of bargaining units in this industry. A *per se* rule could result in the Board's giving insufficient attention to this admonition of the Congress, and could permit the splitting of professional or other employees into separate units regardless of whether the particular circumstances warranted such a division.

250 N.L.R.B. at 411.

Of course, the Board has now discarded its earlier pronouncements by adopting just such a *per se* approach.¹⁶ In so doing, it failed to distinguish or even acknowledge its previous interpretations.

¹⁶The Board was not unanimous in its decision to abandon earlier precedent and interpretation. In dissenting from the final rule, Board member Wilford W. Johansen found that under the basic rules of statutory construction, the language of Section 9(b) ("the Board shall decide in each case") is mandatory rather than permissive. Johansen also stated his belief that the Board could not satisfactorily fulfill its statutory obligations under Section 9(b) by relegating the specialized, fact-oriented task of determining bargaining units to blanket rulemaking. Member Johansen noted that while rulemaking is

(Continued . . .)

This Court has final responsibility for interpreting Section 9(b). Because the Board's latest interpretation of the statute in its commentary to the rulemaking contradicts its own prior interpretation, it is entitled to very little deference. See *NLRB v. United Food and Commercial Workers Union*, 484 U.S. 112, 124 & n.20 (1987); *County of Washington v. Gunther*, 452 U.S. 161, 177-78 (1981). Moreover, reviewing courts must reject administrative constructions of statutes, whether reached by adjudication or rulemaking, where, as here, they are inconsistent with the statutory mandate or frustrate the policy that Congress sought to implement. *Federal Election Campaign Comm'n v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981).

B. The Rule Violates The Congressional Directive Against Unit Proliferation

Congress' purpose in enacting the 1974 amendments was to bring stability to an industry which provides the most essential of services to the American people. The 1974 amendments provided an orderly mechanism by which health care employees could engage in or refrain from engaging in self-organization through the Board's secret ballot election procedures rather than through confrontational recognition disputes. Congress also

¹⁶ (... Continued)

desirable and appropriate in some areas, bargaining unit determination is not one of those areas.

That is not only because the rules themselves are less flexible, but also because the nature of the evidence on which the rule is based is in turn more generalized — primarily anecdotal and statistical — and therefore lacks the quality of pertinent evidence regarding a specific situation which lies at the core of the decisional process.

Final Rule, 54 Fed. Reg. at 16,347.

sought to provide health care institutions and their patients with protection against the disruption of service that is likely to result from proliferation of bargaining units. See discussion *supra* at Section I(A), and *AHA Petition* at 21-26.

Congress found that unit proliferation brings with it a potential for severe operational disruptions from multiple organizing efforts, multiple negotiations, the issuance of multiple strike notices under Section 8(g) of the Act, and increased numbers of employees and patients who would be affected by potential strikes.

In considering legislation to amend the Act, it was immediately recognized that the health care industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that "[h]ospital care is not storable."

St. Francis of Lynwood, 601 F.2d at 411.

In *St. Francis of Lynwood*, the Ninth Circuit held that a *per se* rule establishing a separate bargaining unit for registered nurses was "clearly" inconsistent with the congressional directive that the Board give "due consideration" to preventing proliferation of bargaining units in the health care industry and Congress' approval of the trend toward broader units. 601 F.2d at 414. See also *NLRB v. HMO International*, 678 F.2d 806, 812 (9th Cir. 1982). The new rule's mandatory registered nurse and skilled maintenance units also have been held to violate the nonproliferation directive by many other circuits, as well as by the Board, when applying standards implementing that directive. See discussion *supra* at Section I(B).

If enforced, the rule will impose on hospitals the bargaining unit proliferation and consequent harm which Congress instructed the Board to avoid and which has caused courts repeatedly to deny enforcement of the Board's orders in health care bargaining unit cases.

III. The Rule Is Arbitrary And Capricious

Agency action is not accorded the same degree of deference as legislation drafted by Congress. In *Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 43 & n.9 (1983), this Court rejected the argument that the arbitrary and capricious standard requires "no more than the minimum rationality a statute must bear in order to withstand analysis under the Due Process Clause."¹⁷ A number of factors must be analyzed to determine whether agency action is arbitrary and capricious.

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 42.

Where the rule is a clear departure from past agency action, the degree of deference accorded to the agency is diminished and the agency must explain its reasoning.

¹⁷Review under the arbitrary and capricious standard is by no means a rubber-stamp process. "[U]nless we make the requirements for administrative action strict and demanding, [agency] expertise . . . can become a monster which rules with no practical limits on its discretion." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 48-49 (citations omitted).

"An agency's view of what is in the public interest may change, either with or without a change in circumstances. But an agency changing its course must supply a reasoned analysis . . ." *Id.* at 57. "[S]harp changes of agency course constitute 'danger signals' to which a reviewing court must be alert." *Natural Resources Defense Council, Inc. v. EPA*, 790 F.2d 289, 298 (3d Cir. 1986), *cert. denied*, 479 U.S. 1084 (1987) (citations omitted). See also *Sierra Club v. United States Army Corps of Engineers*, 772 F.2d 1043, 1046 (2d Cir. 1985) ("A change in something from yesterday to today creates doubt. When the anticipated explanation is not given, doubt turns to disbelief."). Even where agency action is supported by "substantial evidence," it may in another regard be arbitrary and capricious if it is an abrupt and unexplained departure from agency precedent. *Association of Data Processing v. Board of Governors of the Federal Reserve System*, 745 F.2d 677, 683 (D.C. Cir. 1984) (Scalia, J.).

A. The Board Did Not Explain Its Radical Departure From Prior Analysis And Interpretation

The rulemaking record contains many clear departures from past agency pronouncements that either lack or defy plausible explanation. For example, the Board has failed to provide any explanation for its total abandonment of the principles announced in *Newton-Wellesley Hospital*, 250 N.L.R.B. 409, 411 (1980), where it stated that the establishment of *per se* bargaining unit rules in the health care industry would violate both Section 9(b) and the nonproliferation mandate.

Another example is the Board's startling about-face in its characterization of the health care industry as homogeneous. In 1984, the Board conceded that "[the] diverse nature of today's health care industry . . . precludes any generalization as to the appropriateness of any particular

bargaining unit." *St. Francis II*, 271 N.L.R.B. at 953 & n.39. As a result, the Board concluded that it was necessary to examine the particular facts (applying a disparity of interests test) in each case and decide, on the basis of those facts, the appropriate unit. There is nothing in the rulemaking record to establish that the health care industry has become *less* diverse than it was in 1984. In fact, the converse is true.¹⁸ If such diversity required case-by-case consideration in 1984, it certainly requires it today. The Board has failed to articulate any reasons supporting this change in its position.

Moreover, the Board inexplicably declined to use either the community of interests test or the disparity of interests test in promulgating its final rule. In other words, for rulemaking, the Board chose to abandon *both* the traditional standard that it had used for other industries (and the health care industry prior to 1984) *and* the standard mandated by the Ninth and Tenth Circuits (and used by the Board in health care adjudication after 1984). Without a reasoned analysis supporting its departure from years of precedent, the Board stated that it would "attempt to avoid the doctrinal formulations utilized under adjudication" and substitute an "empirical" approach with no guiding standard.¹⁹ *NPR II*, 53 Fed. Reg. at 33,905-906.

¹⁸See, e.g., Transcript, Hearing on Proposed Rulemaking on Collective Bargaining in the Health Care Industry, Sept. 14, 1987, at 3192-3197 (testimony of Duane Dauner, President of CAHHS).

¹⁹The Board did state that it would endeavor to create units reflecting "natural groupings" of health care employees. *NPR II*, 53 Fed. Reg. 33,905. It further purported to steer a course between groupings so large that organizing would be "exceedingly difficult" and so small that the congressional concerns regarding proliferation would be realized. *Id.*

Although the Board indicated that it would continue to rely on factors "similar" to those which guided previous adjudication (*id.* at 33,905), this simply is not true. Nowhere is the Board's complete abandonment of prior interpretation and analysis more evident than in its rulemaking with respect to registered nurses. In *NPR I*, the Board tentatively proposed a separate unit of registered nurses even though such a unit was completely inconsistent with the most recent three adjudications,²⁰ and the Board, as yet, had no additional evidence to support its departure from such precedent. To achieve this result, the Board radically altered its approach and emphasis in evaluating unit appropriateness. Thus, the Board cited several general factors as supporting the separateness of registered nurse units, most of which it had considered either *irrelevant* or *insubstantial* in prior adjudication, and some of which it previously had cited as, in fact, *favoring the combination of registered nurses with other professionals*.²¹

²⁰See *Middletown Hospital Ass'n*, 282 N.L.R.B. 541 (1986); *North Arundel Hospital Ass'n*, 279 N.L.R.B. 311 (1986); *Keokuk Area Hospital*, 278 N.L.R.B. 242 (1986).

²¹The factors cited by the Board in *NPR I* as support for a separate registered nurse unit are that nurses:

- (a) Usually work "round the clock, 7 days a week";
- (b) Have "constant responsibility for direct patient care";
- (c) Are "subject to common supervision by other nurses";
- (d) Share "similar education, training, experience and licensing that are not shared by other employees";
- (e) Have more frequent contact with other registered nurses than with other professionals;
- (f) Have "a lengthy history of organization, both professionally and for purposes of collective bargaining"; and

(Continued . . .)

In *NPR II*, the Board continued to assign entirely different significance to facts that had been available in prior adjudication with regard to registered nurse units. It continued to apply, in a manner entirely inconsistent with prior case law, the various factors that it had listed

²¹ (. . . Continued)

(g) Comprise "the largest group of professional employees at most health care facilities."

See *NPR I*, 52 Fed. Reg. at 25,146-147. See also *NPR II*, 53 Fed. Reg. at 33,911.

In *Keokuk Area Hospital*, 278 N.L.R.B. 242 (1986) and *North Arundel Hospital Ass'n, Inc.*, 279 N.L.R.B. 311 (1986), the Board considered and expressly dismissed factors (a), (b), (c), (d) and (e) as being insufficient to warrant separate registered nurse units. Indeed, with regard to factor (b), the Board stated that "the concept of direct versus indirect patient care has long been rejected as a basis for making unit determinations in the health care industry." *North Arundel Hospital Ass'n*, 279 N.L.R.B. 311, 312 n.7 (citing *Bay St. Joseph Care Center*, 275 N.L.R.B. 1411 (1985)) (emphasis added). With regard to factors (c) and (d), the Board stated that such criteria are "equally applicable" to other professional employees, and "carried to its logical extreme," reliance thereon could result in separate bargaining units for each of the other professional classifications, "a result plainly at odds with the congressional directive against unit proliferation." *Id.* at 312. As to factor (g), the Board in adjudication found that the disparity in size between the registered nurse group and other professionals actually favored the establishment of a broader all-inclusive unit rather than allowing for a residual unit which is comprised of a relatively small proportion of the employer's professionals. *Id.* at 312, n.9. Finally, although factor (f) was not noted in the aforementioned cases, obviously such information about the history of organizing was available to the Board at the time. Accordingly, the Board's reliance upon such a factor in rulemaking further underscores its sudden and unexplained change of emphasis. Moreover, for the reasons set forth *infra* at Section III(B), pp. 25-29, the Board is statutorily precluded from ultimate reliance upon this factor.

in *NPR I*. See *NPR II*, 53 Fed. Reg. at 33,911-917 and cases cited *supra* note 20. In addition, it inexplicably reversed its position on other factors. For example, the Board found persuasive the fact that there is limited cross-training and interchange between registered nurses and other professionals because of licensing requirements. *NPR II*, 53 Fed. Reg. at 33,913. However, the Board had expressly disclaimed the relevance of this factor in prior adjudication. See, e.g., *North Arundel Hospital Ass'n*, 279 N.L.R.B. at 312. See also *St. Francis of Lynwood*, 601 F.2d at 419-20.

A further example of the Board's result-oriented fickleness is its treatment of evidence that hospitals are increasingly utilizing a "multi-disciplinary team" approach to patient care, which combines registered nurses with various other classifications. When evaluating such information on a case-by-case basis, the Board had found the use of such teams to be an important factor in denying separate registered nurse units. See *North Arundel Hospital Ass'n*, 279 N.L.R.B. at 312; *Keokuk Area Hospital*, 278 N.L.R.B. at 243. However, in rulemaking, the Board stated that hospitals unsuccessfully had relied upon the existence of such multi-disciplinary teams in attempting to defeat the 1974 health care amendments, and that "the team concept remains non-persuasive . . ." ²² *NPR II*, 53 Fed. Reg. at 33,913.

²² Among the reasons cited by the Board for rejecting the team concept in rulemaking is that "the evidence at the [rulemaking] hearing established that many hospitals do not even use the team concept." *NPR II*, 53 Fed. Reg. at 33,913. If anything, this emphasizes the unsuitability of rulemaking for bargaining unit determinations. It undermines the Board's rationale for establishing mandatory bargaining units on an industry-wide basis; namely, that all acute care hospitals are essentially identical in all material

(Continued . . .)

An exhaustive recitation of the Board's unexplained departures from the analytical models of prior adjudication in this area would be impossible within the page limitations allowed for this brief. However, the rulemaking record is replete with them. Moreover, such inconsistencies are not confined to the Board's consideration of registered nurse units. Similarly disturbing discrepancies between adjudication and rulemaking appear in the Board's treatment of skilled maintenance units²³ and business office clerical units²⁴.

B. The Board Gave Controlling Weight To Irrelevant And Impermissible Factors

An agency's rule will be held arbitrary and capricious when it relies on factors which Congress did not intend to be part of the rulemaking equation. Such a transgression

²³ (... Continued)

respects. See *NPR I*, 52 Fed. Reg. at 25,145; *NPR II*, 53 Fed. Reg. at 33,903-904. Case-by-case adjudication clearly is necessary so that institutions which do have multi-disciplinary professional teams, such as North Arundel Hospital and Keokuk Area Hospital, can have the Board consider that factor. As previously noted, the Board's final rule precludes such consideration because the team concept, having already been considered in rulemaking and prior adjudication, would not be classified as an "extraordinary circumstance." See discussion of "extraordinary circumstances" exception *supra* note 15 and accompanying text.

²³ Compare *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) [*St. Francis II*] and *St. Francis Hospital*, 286 N.L.R.B. 1305 (1987) [*St. Francis III*] (in which the Board found that the hospital's skilled maintenance employees were not entitled to a separate unit) with the rulemaking commentary in *NPR II*, 53 Fed. Reg. at 33,920-924.

²⁴ Compare *Baker Hospital*, 279 N.L.R.B. 308 (1986) (business office clerical employees not entitled to separate unit because there are no sharper than usual differences to demonstrate a disparity of interests between such employees and other non-professionals) with the commentary in *NPR II*, 53 Fed. Reg. 33,924-926.

occurred here. It is true, as asserted by the Board, that the rulemaking hearings produced some "empirical data" which may not have been available in prior adjudication. However, such data was used in a manner contrary to Congress' intent.

The data essentially was limited to two general categories: (1) that which addressed the validity of congressional concerns about strikes, jurisdictional disputes, wage leapfrogging, whipsawing and the like; and (2) that which showed the preferences of unions for organizing among certain groups of health care employees. See *NPR II*, 53 Fed. Reg. 33,908-910; 33,915; 33,922; 33,925.

The Board argues from the first category of data that experience shows congressional concerns about the effects of health care unit proliferation to have been unwarranted. *NPR II*, 53 Fed. Reg. 33,906-910. However, the value of such data, even assuming its completeness and accuracy, is extremely dubious. First, it is data based upon experience under a *different standard* from that which the Board now seeks to implement. In other words, it is data from a period in which *no bargaining unit proliferation in the health care industry existed*. From 1974 until 1984, the courts prevented the Board from allowing units to proliferate to the extent now provided by the final rule. And from 1984 to the present, the Board has stayed its own hand.

In any event, it is not the Board's province to second-guess Congress. Whether or not statistics *now* substantiate the concerns expressed in 1974, Congress directed the Board to avoid proliferation of health care bargaining units. The Board has no authority to repeal by rulemaking the legislative history of the 1984 health care amendments.

What remains, then, is the Board's compilation of data concerning the desires of unions (and allegedly their constituents) to organize into units which mirror the configuration established in the final rule. A review of the rulemaking record compels the conclusion that the Board gave controlling effect to this factor. That is because the only material and significant respect in which the rulemaking record differs from evidence produced in prior case-by-case adjudication is statistical evidence showing the extent to which unions have sought to organize in those units previously considered inappropriate (i.e., registered nurses, business office clerical employees and skilled maintenance employees).²⁵

The Act specifically prohibits the Board from giving controlling effect to such considerations. Section 9(c)(5) of the Act provides that "[i]n determining whether a unit is appropriate for the purposes specified in subsection (b) [of this section] the extent to which the employees have

²⁵ Attempting to justify its reliance on this factor, the Board stated that a legitimate consideration in bargaining unit determinations is whether organizing will be impeded by the size and composition of the unit. *NPR II*, 53 Fed. Reg. at 35,910. However, there is no evidence in the rulemaking record to support a conclusion that the units uniformly found appropriate in recent adjudication (applying the disparity of interests test) impeded organizing. Indeed, there is statistical evidence to the contrary. Testimony showed that during the period 1984-87 (when the Board was applying the disparity of interests test), unions in southern California won 11 of 15 hospital elections (73%) conducted in broader units, i.e., all employees, all professional employees, or all non-professional employees. See Transcript, Hearing on Proposed Rulemaking on Collective Bargaining in the Health Care Industry, Sept. 15, 1987, pp. 3398-3431 (testimony of Arthur Sponseller, Vice President Human Resources, HCSC). By contrast, the percentage of elections won by unions in all industries nationwide has ranged between approximately 46% and 50%. See 1990 DAILY LAB. REP. (BNA) at A-6 (April 27, 1990).

organized shall not be controlling." 29 U.S.C.A. § 159(c)(5) (West 1973).

Construing this provision, this Court has held that while the Board may consider the extent of organizing as one factor, it may not be the controlling factor in bargaining unit determinations. *NLRB v. Metropolitan Life Insurance Co.*, 380 U.S. 438, 442 (1965). This Court has indicated that the Board must articulate reasons other than those prohibited by § 9(c)(5) and, where necessary, show that the extent of organizing was not the controlling factor by adequately distinguishing prior decisions which might create such an inference. *Id.*

Here, as noted, the Board has failed to establish any meaningful distinction between those adjudicated cases in which it found registered nurse, skilled maintenance and business office clerical units to be inappropriate and the current quasi-legislative rule in which it finds them to be *per se* appropriate, other than statistical evidence establishing the preference of unions to organize on that basis. Moreover, the Board revealed its hand in this regard with its very first announcement of rulemaking. In *NPR I*, the Board made reference to the "many hundreds of petitions for health care units" that it had received in the last thirteen years, and noted that the units requested generally fell into certain "predictable groupings" of employees. Among those predictable groupings were registered nurses. In the very same notice *and before any rulemaking hearings had taken place*, the Board proposed a rule for large hospitals (100 beds or more) which would mandate units consisting exclusively of registered nurses. As previously described, this was patently inconsistent not only with the decisions of the Courts of Appeals, but also with the decisions of the Board in *every individual case* in which it had considered the registered nurse unit

issue since 1984. The Board, at that point, clearly had *no basis* to depart from such precedent, other than the predictability that petitions would be filed for registered nurse units by the American Nurses Association's state affiliates and other organizations solely interested in organizing nurses.

The courts have not hesitated to deny enforcement of the Board's bargaining orders where it appears that the Board's unit determination contravened § 9(c)(5). *See, e.g., Westward-Ho Hotel Co. v. NLRB*, 437 F.2d 1110 (9th Cir. 1971); *NLRB v. Pinkerton's, Inc.*, 428 F.2d 479 (6th Cir. 1970); *NLRB v. Purity Food Stores, Inc.*, 354 F.2d 926 (1st Cir. 1965); *NLRB v. Capital Bakers, Inc.*, 351 F.2d 45 (3d Cir. 1965). There is no reason why a more deferential standard should apply when the bargaining unit determination is by APA rulemaking. *See Securities Industry Ass'n v. Board of Governors of the Federal Reserve System*, 468 U.S. 137, 143 (1984) (reviewing court must reject agency decisions inconsistent with statute whether reached by adjudication or by rulemaking).

The Board's conduct in this matter is strikingly similar to that which was found unlawful by the Ninth Circuit Court of Appeals in *Westward-Ho Hotel*. In that case, the court concluded that the Board had departed from prior decisions and standards by finding appropriate a unit limited to the hotel's kitchen employees, rather than a combined unit of kitchen, dining room and housekeeping employees. Although the Board had articulated seven reasons for its bargaining unit determination, the court concluded that six of them either could not be reconciled with prior decisions or were otherwise insupportable. The only remaining articulated rationale (the fact that no other labor organization had sought a broader unit) "strongly suggested" to the court that "the Board's ac-

tion was controlled by extent of organization." *Id.* at 1115. As a result, the court refused to enforce the Board's order to bargain in the unit at issue.

In so doing, the court criticized the Board's view that any well-defined and functionally coherent group of employees that it finds to be appropriate must be upheld as such by a reviewing court.

It is well-settled, of course, that the Board has a singularly wide discretion to determine appropriate bargaining units. *See, e.g., Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491-493, 67 S.Ct. 789, 91 L.Ed. 1040 (1947); *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 132-135, 64 S.Ct. 851, 88 L.Ed. 1170 (1944). But the Board's discretion is not unlimited. Both the legislative history of § 9(c)(5) and the Supreme Court's decision in *NLRB v. Metropolitan Life Ins. Co.*, *supra*, make it clear that the mere fact that the Board selects a unit consisting of a well-defined and functionally coherent group of employees does not by itself mean that its determination must be accepted by a reviewing court. We agree with *Local 1325, Retail Clerks Int'l Ass'n, AFL-CIO v. NLRB*, *supra*, at 1201, that *where prior Board decisions suggest that a unit determination was arbitrary or has been controlled by extent of organization, the Board must give reasons for its choice that effectively rebut the inference that it has acted improperly.*

Id. at 1115-1116 (footnote omitted) (emphasis added).

After examining the Board's decisions in similar cases and finding no adequate articulated basis for the different result, the court stated:

[T]he Board's action here seems to be a retrogression to *Botany Worsted Mills*, 27 N.L.R.B. 687

(1940), which appears from the legislative history of § 9(c) (5) to have been the kind of unit determination Congress intended to preclude. The House Report on § 9(c) (5) expressly criticized that decision as an example of a case in which "the Board *pretends to find reasons other than the extent to which the employees have organized as ground for holding such units to be appropriate.*" H.R. Rep. No. 245, 80th Cong., 1st Sess. 37 (1947).

Id. at 1116 (emphasis added).

In sum, the Board refused to explain its abrupt and complete departure from prior analysis and ultimately relied on impermissible factors to establish its *per se* eight bargaining unit rule. Accordingly, the rule is arbitrary and capricious.

CONCLUSION

The rule is an arbitrary and capricious exercise of power by the National Labor Relations Board which violates the National Labor Relations Act. The decision of the United States Court of Appeals for the Seventh Circuit should be reversed.

Respectfully submitted.

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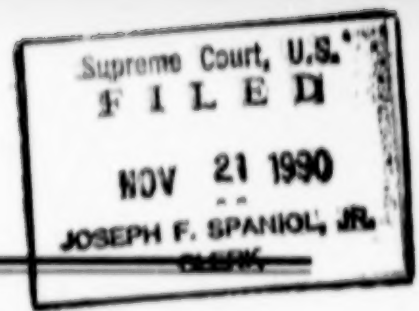
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November 21, 1990

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No. 90-97



IN THE
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

On Petition For A Writ Of Certiorari To The United
States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF
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IN THE
Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

On Petition For A Writ Of Certiorari To The United
States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF
THE VIRGINIA HOSPITAL ASSOCIATION

I. INTEREST OF THE AMICUS CURIAE

The Virginia Hospital Association submits its brief as *amicus curiae* in support of the Petitioner, the American Hospital Association.¹ The Virginia Hospital Association ("VHA") is a private non-profit membership organization which serves as an advocate for the Virginia hospital industry providing leadership, representation and services to its member hospitals. The VHA strives to serve its members by developing and promoting programs that will enhance the

¹ All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

ability of its members to provide comprehensive, efficient, quality health care to all Virginians.

The VHA has ninety-five acute care hospital members representing all the acute care hospitals in the State of Virginia. The VHA has a diverse membership with hospitals of varying sizes and missions. Some of its hospital members are located in metropolitan areas such as Richmond or Northern Virginia locales surrounding Washington, D.C. Many other acute care hospital members of the VHA are located in rural areas throughout Virginia. The complexity of services offered at each hospital also varies. Some hospitals are primary care hospitals while others provide tertiary level care in a number of specialty areas. Some of the acute care hospital members of the VHA have mental health units in their facilities while others combine acute care with long-term rehabilitative care.

The largest acute care hospital member of the VHA is Fairfax Hospital ("Fairfax") located in Falls Church, Virginia, with over 4,600 employees and 656 beds. Equally representative of the membership of the VHA, however, is Bath County Community Hospital, a small rural hospital in Hot Springs, Virginia, with approximately 85 employees and 25 beds. In fact, over twenty-five percent of the VHA's hospital members have less than 100 beds. All acute care hospital members of the VHA will be subject to the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry ("Final Rule" or the "Rule"). 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30 (1989). Thus, all acute care hospital members of the VHA have a vital interest in the American Hospital Association's challenge to the Final Rule promulgated by the NLRB.

The Board's Final Rule provides for eight bargaining units within acute care hospitals. The Rule specifies that the eight units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units deemed appropriate by the Board are: "(1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30.

The Rule contains an "extraordinary circumstances" exception which permits the filing of petitions seeking representation of bargaining units which are not in substantial accordance with the provisions of the Rule. See Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33,932-33 (1988). The Board's "extraordinary circumstances" exception, however, is extremely narrow. The Board has expressly foreclosed consideration of additional evidence or arguments demonstrating that a particular hospital varies from the norm, even if the variation is "highly unusual". *Id.* at 33,932. Hospitals bear a "heavy burden" to show the existence of extraordinary circumstances rendering application of the Rule inappropriate. *Id.* at 33,933. Specifically, the Board has announced that "increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of 'team' care, and cross-training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33,932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also be disregarded as extraordinary circumstances justifying relief from the Rule. *Id.*

One acute care hospital member of the VHA is currently involved in representation proceedings before the Board.² On January 17, 1990, the District of Columbia Nurses Association ("DCNA") filed a petition with the NLRB, designated Case No. 5-RC-13331, seeking to represent a unit of approximately 1200 registered nurses at Fairfax Hospital. Action on the union's petition was stayed by the injunction issued in this case by the United States District Court for the Northern District of Illinois. The United States Court of Appeals for the Seventh Circuit reversed the decision of the district court on April 11, 1990, and vacated the district court's injunction against enforcement of the Board's Final Rule. The American Hospital Association obtained a stay of the court of appeals' order, pending this Court's ruling on the petition for a writ of certiorari. The writ of certiorari was granted on October 9, 1990.

² One other hospital, Mary Washington Hospital, won a representation election on November 15, 1990, when employees at the hospital voted against representation by the Laborers' International Union of North America.

If the decision of the Seventh Circuit is upheld, however, it is expected that Region 5 of the NLRB will quickly proceed to apply the Board's Final Rule to the petition for representation of registered nurses at Fairfax Hospital. The Region will certify the proposed unit of registered nurses as an appropriate bargaining unit at Fairfax Hospital without considering whether the special circumstances of employment at the hospital warrant certification of a different bargaining unit, perhaps one which would include all health care professionals at the hospital. If the Seventh Circuit's decision is not reversed, any argument by Fairfax Hospital as to the appropriateness of alternative bargaining units will be foreclosed.

Three of the acute care hospital members of the VHA have employees who are represented by unions. These hospitals have experienced the substantial costs associated with negotiating and administering contracts with union representatives. Those hospitals which have already been organized by unions or which await application of the Board's Final Rule to pending representation petitions have relevant information to bring to bear on the question of the validity of a *per se* bargaining unit rule which would impose as many as eight bargaining units on health care workplaces without affording hospitals an opportunity to be heard on the issue of the appropriateness of such units.

The Board's Final Rule also ignores the differences between acute care hospitals in Virginia, differences which in any particular case make application of the Rule an arbitrary and capricious encroachment on the rights of member hospitals of the VHA to deal with their employees over wages, hours and working conditions. The Rule also ignores significant trends within acute care hospitals in Virginia including the development of mechanisms within hospitals for increasing the coordination and integration of health care delivery to patients. The Board's Final Rule will only lead to increased disruption within Virginia hospitals and an increase in costs for acute care hospitals already struggling to meet budgetary constraints. The Virginia Hospital Association is thus extremely interested in the issues presented by this case and believes it can illuminate the reasons why application of the Board's Final Rule will be harmful to acute care hospital members of the VHA.

II. SUMMARY OF THE ARGUMENT

The issue for resolution in this case is whether the NLRB has acted outside its statutory authority in adopting a rule which conclusively presumes that only eight bargaining units are appropriate for acute care hospitals. The Virginia Hospital Association supports the argument of Petitioner in this case that the Board's Final Rule and its *per se* application to all representation petitions involving acute care hospitals contravenes Section 9(b) of the National Labor Relations Act (the "Act") which requires the Board to determine appropriate bargaining units "in each case". 29 U.S.C. § 159(b). The "in each case" language of Section 9(b) clearly requires adjudication of particular facts in individual cases to determine the appropriate bargaining unit. Therefore, any rule promulgated by the Board which attempts to set uniform standards for bargaining unit determinations must also provide health care employers in particular cases with a meaningful opportunity to demonstrate that there are facts which are peculiar to their facility. If it does not, the rulemaking is invalid as contrary to the language of the Act. It is abundantly clear that the Board's intention in issuing its Final Rule was to preclude individual hospital employers from challenging the Board's determination that only certain bargaining units are appropriate within acute care hospitals. If the Seventh Circuit's decision is not reversed, acute care hospital members of the VHA will be denied a meaningful opportunity to explore the appropriateness of alternative bargaining units in response to future representation petitions.

The Board's Final Rule also ignores the congressional admonition against proliferation which is contained in the legislative history of the Health Care Amendments Act of 1974. Although the Board stated its concern for the admonition against proliferation during the rulemaking proceeding, it is evident that the Final Rule actually promotes proliferation and will substantially increase administrative costs for acute care hospitals in Virginia. The Board has proceeded with rulemaking without concern for the significant costs involved in administering contracts with employee representatives. By disregarding the costs of a rule mandating eight bargaining units within acute care hospitals, the Board ignores the consequences that its prescription for proliferation will visit upon acute care hospitals. In ignoring the

consequences of its action, the Board's claim that it has heeded the congressional admonition against proliferation rings hollow.

Finally, the Board's Final Rule is arbitrary and capricious because it disregards the special circumstances of employment at acute care hospitals in Virginia and threatens to disrupt the delivery of quality health care at those institutions. The arbitrariness of the Board's Rule is underscored by its potential application to all acute care hospitals within Virginia despite the differences in size or complexity of services at each institution. The injustice imposed on acute care hospitals within Virginia by the Board's Final Rule can only be avoided by reversal of the Seventh Circuit's decision and reinstatement of the district court's permanent injunction prohibiting implementation of the Rule.

III. ARGUMENT

When the Board announced in 1987 that it would undertake rulemaking to promulgate a rule of general application to all acute care hospitals in the health care industry, health care employers envisioned rules of general application to representation proceedings which would nevertheless allow individual employers, in any particular case, the opportunity to demonstrate that the unique characteristics of their workplaces required a variation on the standardized bargaining units proposed by the Board. On April 21, 1989, the Board issued its Final Rule establishing eight bargaining units as conclusively appropriate in acute care hospitals. 54 Fed. Reg. 16,336 (1989). Rather than establish rebuttable guidelines for determining bargaining units, the Board crafted a rule which was rigid and inflexible, allowing no meaningful challenge by health care employers to its application in any particular case.

The Petitioner in this case, the American Hospital Association, challenged the Board's Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court granted a permanent injunction preventing the Board's Final Rule from being implemented. *American Hosp. Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule failed to heed the congressional admonition against undue proliferation of bargaining units in the health care industry. The court stated:

A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

718 F. Supp. at 716.

The United States Court of Appeals for the Seventh Circuit overturned the decision of the district court and vacated the injunction. *American Hosp. Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990). The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case by case determination of bargaining units. The court also held that the congressional admonition against proliferation of units in the health care field did not prohibit implementation of the Rule. Finally, the court of appeals rejected the American Hospital Association's argument that the Rule is arbitrary and capricious because it fails to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 659.

A. Section 9(b) Of The Act Requires That Health Care Employers Be Afforded A Meaningful Opportunity To Be Heard On The Appropriateness Of Petitioned-For Bargaining Units

For over fifteen years, the Board has used a case by case adjudicatory approach for determining appropriate bargaining units in acute care hospitals. Hospitals facing statutorily imposed obligations with respect to bargaining with unions were afforded the opportunity to create a factual record as to the appropriateness of bargaining units prior to the Board's action on a pending representation petition. The Board's case by case representation procedures quite correctly allow employers to participate in a meaningful manner in discussions relating to important bargaining unit issues. The Virginia Hospital Association contends that the opportunity to be heard is a requisite element of any representation procedure utilized by the Board. Only a rule which allows both parties the opportunity to argue the ap-

propriateness of a proposed unit is consistent with the requirement of Section 9(b) of the Act.

In contrast, the Board's Final Rule denies health care employers confronted with representation petitions the opportunity to argue that only certain bargaining units are appropriate because of the special circumstances of employment at their institutions. The Board has now mandated the appropriateness of certain bargaining units almost without exception. The Board's Final Rule creates a conclusive presumption that precludes participation by one of the interested parties to the representation proceeding, the health care employer. As stated by the Board during its rulemaking proceeding:

We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers.... Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations....

NPR I, 52 Fed. Reg. 25,142 (1987).

The Board's decision to adopt a conclusive or irrebuttable presumption instead of a rebuttable presumption results in a rule that is inconsistent with the mandate in Section 9(b) to make bargaining unit determinations "in each case." As argued above, that language mandates consideration of specific facts in each case. Unless interested parties are afforded an opportunity to rebut the presumptions created by the Board's Final Rule, the Board's Rule contravenes the Act and thus is invalid. The Board has discretion to promulgate rules only so long as they are consistent with the Act. *See Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 501 (1978); *see also* Note, *NLRB Guidelines for Determining Health Care Industry Bargaining Unit: Judicial Acceptance or Back to the Drawing Board*, 78 Ky. L.J. 143, 158-61 (1989).

Section 9(b) of the National Labor Relations Act provides in pertinent part:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit ap-

propriate for the purposes of collective bargaining shall be the employer unit, plant unit, or subdivision thereof....

29 U.S.C. § 159(b).

In spite of the clear directive in Section 9(b) that the Board determine an appropriate bargaining unit "in each case", the Board proposes to implement a *per se* rule which makes eight bargaining units appropriate in all acute care hospitals regardless of their size or the complexity of their operations. In promulgating the Rule, the Board exceeded its rulemaking authority because it declared a new bargaining unit rule that is in direct conflict with the plain language of the statute. Therefore, the Board's Final Rule must be invalidated.

This Court has consistently held that where the language of an act is plain, it must be enforced according to its terms. *See Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain, ... the sole function of the courts is to enforce it according to its terms."); *see also Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980) ("[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.").

In order to give statutory language its conclusive effect, congressional intent need only be expressed with sufficient precision in the act. *See United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989) (finding that the inquiry into the meaning of § 506(b) of the Bankruptcy Code should begin and end with the language of the statute itself); *see also INS v. Cardoza Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring) ("Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent."); *Commissioner of Internal Revenue v. Asphalt Prods. Co.*, 482 U.S. 117, 121 (1987) ("Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided.").

In addition, despite the deference generally accorded to agency interpretations of statutes, the Board's discretion and this Court's deference to the agency's interpretation of Section 9(b) of the National Labor Relations Act "is constrained by [this Court's] obligation to honor the clear meaning of a statute, as revealed by its language, purpose and history". *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The principle of deference to an agency's construction of a statute is not applicable where statutory language is unambiguous. As stated by this Court in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.

Id. at 842.

The Board's disregard for the "in each case" requirement of Section 9(b), as evidenced by its promulgation of a *per se* rule for determining bargaining units, should be rejected in view of the plain language of the Act and prior conflicting interpretations by the Board concerning its duty under the National Labor Relations Act to determine bargaining units "in each case". Even though the Board now maintains that certain "pre-ordained" bargaining units are *per se* appropriate, the Board, in the past, frequently stated that generalizations as to appropriate bargaining units are not appropriate. See *Otis Hosp., Inc.*, 219 N.L.R.B. 164 (1975) ("[N]ot all health care institutions may be exactly alike.... Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise."); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980) ("in each case" requirement of Section 9(b) held to preclude a *per se* approach to bargaining unit determinations); *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39, 954 (1984) (diverse nature of the health care industry found to preclude

any generalizations as to the appropriateness of particular bargaining units; "No unit is *per se* appropriate and ... separate representation must be justified upon each factual record....").

This Court has declined to defer to an agency's decision where the agency's position is inconsistent with earlier interpretations. See *INS v. Cardoza Fonseca*, 480 U.S. at 446 n.30 ("An agency's interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."). The NLRB has construed "in each case" language in another statute, the Postal Reorganization Act, as requiring case by case determinations of bargaining units. In *United States Postal Serv.*, 208 N.L.R.B. 948, 952-53 (1974), the Board followed its traditional community of interests analysis in considering the appropriateness of certain bargaining units involving the Postal Service. Language in the Postal Reorganization Act persuaded the Board to analyze the petitions on a case by case basis. That language reads: "The National Labor Relations Board shall decide in each case the unit appropriate for collective bargaining in the Postal Service...." 39 U.S.C. § 1202. No justification exists for departing from a case by case analysis of health care industry petitions where identical language in Section 9(b) also mandates bargaining unit determinations on a case by case basis.

Application of the Rule will prevent hospitals from arguing the appropriateness of alternative bargaining units in response to petitions pending before the NLRB. The variables that make each hospital unique will go unnoticed if the Board's new Rule is allowed to be implemented. For instance, the petition for an all RN unit at Fairfax Hospital will undoubtedly be approved without a specific analysis of employment conditions at Fairfax. If the union is successful in convincing registered nurses at Fairfax Hospital to vote for representation, the hospital will be confronted with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at Fairfax. Such a situation will result in a segregated workforce with some professionals working under work rules governed by the collective bargaining agreement and others working under the policies of Fairfax Hospital.

There are undoubtedly many factors which militate in favor of a broader all professional unit at Fairfax Hospital. Those factors will never come to light if the Board's Rule is applied to the pending petition. A similar unhappy ending will be repeated each time another Virginia hospital is confronted with a representation petition. The Board's narrow "extraordinary circumstances" exception will not allow any health care employer to demonstrate that a community of interests exists in its workplace which is broader than that which is implicit in the bargaining units proposed in the Final Rule. Thus, a hospital which wishes to demonstrate that its technical employees often interact with, or perform duties consistent with the functions of, its nonprofessional employees (i.e., licensed practical nurses performing clerical tasks, assisting or performing housekeeping functions as the need arises, or coordinating meal selection and distribution of menus for patients) will be prevented from demonstrating the integrated nature of its nonprofessional workforce.

The immediate harm that will result to acute care hospitals as a consequence of the Board's decision to abandon case by case adjudication and resort to a *per se* rule regarding bargaining units is obvious in the case of hospitals such as Fairfax Hospital. The hospital is an interested party to its representation proceeding before the Board yet the Board's Rule will effectively prohibit it from presenting any evidence which might demonstrate that the Board's mandated bargaining unit is not appropriate. In the case of Fairfax Hospital, the Rule will have an immediate impact. It can be seen, however, that the proliferation of bargaining units which will be fueled by the new Rule and the resulting increase in administrative costs at other hospitals within Virginia also make the Final Rule unjustifiable.

B. The Board's Rule Ignores The Congressional Admonition Against Undue Proliferation Of Bargaining Units In The Health Care Industry

A crucial issue to be determined in this case is the weight that should be accorded to the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess.

6-7 (1974). The district court in this case found the congressional admonition to be a specific directive to the Board on the manner in which to proceed when determining bargaining units in the health care field. The court said:

[C]ongress drew attention to health care by adding another concern, which *must be addressed by the Board in certifying bargaining units in that industry*. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, *it must use the means least likely to cause unit proliferation to achieve their objective*.

718 F. Supp. at 712 (emphasis added).

The district court found that the Board, in promulgating its new rule, "failed to give more than mere lip service mention of the Congressional admonition". *Id.* at 714. The court concluded that the Final Rule, because it designated an "absolute number of appropriate units" and mandated a "particular division of the workforce", was "not responsive to Congress' express concern". *Id.* at 716.

In contrast, the Seventh Circuit held that the Board's determination that eight bargaining units were *per se* appropriate in acute care hospitals was "entitled to broad judicial deference". 899 F.2d at 656. The court of appeals said:

It is not for us to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions that it does, or slightly fewer.

Id. at 657.

The court of appeals found that the congressional admonition was entitled only to "respectful consideration" and construed Congress' intent as "cautionary rather than directive." *Id.* at 658. The court's decision in this respect is contrary to decisions of other courts of appeals which have given controlling weight to the congressional admonition against undue proliferation. *See, e.g., Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 676, 632 (2d Cir. 1983) (referring to the admonition, the court said: "[T]his legislative commitment to nonproliferation, explicit in the legislative history,

binds the NLRB in its determination of the appropriate collective bargaining unit in a health care institution."); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982) (legislative commitment to nonproliferation is "binding on the NLRB" and requires the Board to "develop a reasoned, non-conclusory method of implementing the statutory intent by articulation of specific criteria"); *St. Anthony Hosp. Sys., Inc. v. NLRB*, 884 F.2d 518, 519-20 and n.3 (10th Cir. 1989) (concluding that the congressional admonition requires that "traditional factors used in ... [bargaining unit] determinations must be put in balance against the public interest in preventing fragmentation in the health care field").

In *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191 (4th Cir. 1982), the Fourth Circuit held that the NLRB must explain how each determination of a bargaining unit implements the congressional admonition against proliferation. The NLRB had sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The court of appeals rejected the Board's decision approving the all RN unit because the NLRB failed to give due consideration to the issue of proliferation of bargaining units at the hospital. 691 F.2d at 194.

The underlying decision of the Board, *Frederick Memorial Hosp., Inc.*, 254 N.L.R.B. 36 (1981), had upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interests, separate and apart from all other professionals, to justify their own unit for bargaining purposes. The Board made a detailed analysis of the working conditions of registered nurses and other allied health professionals at the hospital before concluding that the RN unit was appropriate. The court of appeals approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

The Board may not depend solely on the traditional community of interests test when making a unit determination for health care institution employees. As other courts have held, the Board must give due con-

sideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination ... implement[s] or reflect[s] that admonition"

...

A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the court adequately review the Board's decision and order unless the Board clearly discloses why certification of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194 (citations omitted).

The Board did not give due consideration to preventing proliferation of bargaining units when it framed its Final Rule. Despite the Board's pronouncement in its Second Notice of Proposed Rulemaking that it had "carefully considered the Congressional admonition against proliferation", 53 Fed. Reg. 33,933, the Board did not clearly explain how its Final Rule implements Congress' concern for preventing proliferation. The Board attempts to justify its selection of eight units as appropriate for bargaining by arguing that the increase from two broad units for bargaining (the Board's *St. Francis II* standard) to eight units is not "proliferation", as that term is commonly understood (i.e., to cause to grow or increase rapidly), but rather is only an increase which reflects employee groups which have "separate labor markets". *Id.* at 33,933. Finally, by creating a definitional framework which serves only its own administrative goals, the Board was able to buttress its conclusion that the Final Rule will not result in proliferation by defining proliferation broadly during rulemaking to be the creation of "fifteen to twenty-plus units". *Id.*

The arbitrary selection of fifteen units as the point where proliferation starts does considerable injury to the congressional admonition and ignores the costs and disruption that can occur as a consequence of even one additional unit for bargaining. Even one organized unit can result in substantial administrative costs because

the provisions in a union agreement must be administered separately from personnel policies applicable to nonunion employees. Eligibility for leave may be different for union and nonunion employees. Differences between hospital employee benefit plans and union benefit plans may substantially impact administrative costs. The union's grievance and arbitration procedure is usually quite different from the hospital's grievance procedure. Finally, administering payroll is extremely troublesome for hospital administrators when union and nonunion employees make up the same workforce. These administrative costs will be doubled, tripled, or, in the worst case scenario, octupled by the operation of the Board's Final Rule.

Hospitals already administering two or more contracts with union representatives have found that, although there may be common provisions in each contract, the more substantial administrative costs are not reduced by having similar provisions in several agreements. For example, one of the most costly and time consuming contract administration problems is dealing with grievances from the union concerning alleged violations of the agreement. Because grievances are generally brought on behalf of an individual union member and are quite fact specific, a hospital administrator's task is not made less costly simply because the administrator may have processed a similar grievance from another employee represented by a separate union. Similarly, any grievance that goes to arbitration will have costs that are repeated each time a new grievance is not resolved prior to arbitration. Arbitration also normally involves outside counsel and therefore the costs for such proceedings accelerate rapidly because of attorneys' fees. Thus, one of the most expensive administrative functions relating to contracts with unions is a cost that is repeated over and over again regardless of the administrator's experience with other union agreements.

Even where hospitals have agreements with one union representing different bargaining units within the hospital, the administrative costs are not substantially reduced because of the fact of duplicate representation. This is especially true in the case of negotiating costs. Unions are loathe to negotiate contracts which terminate at the same point in time each year. Unions have increased bargaining leverage by utilizing separate expiration dates for different bargaining units within the hospital. Through the use of recurring § 8(g) notices and

the threat of bargaining unit walkouts by different groups of employees, the union can successfully pressure the hospital administration to accede to its bargaining demands. No self-respecting union will give up collective bargaining leverage and, thus, there are generally no savings realized during negotiations from having the same union represent different groups of employees.

Virginia hospitals are experiencing the same financial difficulties confronting hospitals throughout the nation. Between 1984 and 1987, forty-one member hospitals of the Virginia Hospital Association experienced a negative operating margin. This means that even though the hospitals may have seen an increase in net revenues, their expenses rose quicker than revenues, thus resulting in negative operating margins. More recently, twenty-seven acute care hospital members experienced operating losses in 1989. The majority of these hospitals were located in rural areas.

Utilization statistics of member institutions of the Virginia Hospital Association show that eighty-two hospitals had a decline in occupancy rates during the period 1984-1987, with sixty-five hospitals experiencing a decrease in admissions as well. Occupancy levels for hospitals with operating losses continued to decline in 1988 and 1989. At present, many small hospitals in Virginia are only operating at approximately fifty percent occupancy. In many cases, large urban hospitals are faring no better.

The VHA has three member hospitals with employees represented by unions. These hospitals have experienced the costs and disruption which accompany organized bargaining units within health care work forces. For example, Wise Appalachian Regional Hospital in Wise, Virginia, was hit with a ninety-one day work stoppage in 1986 by the United Steelworkers. The Steelworkers represent registered nurses, other allied health professionals, and nonprofessionals at the hospital. The strike caused disruption in hospital operations and substantial financial losses to the hospital.

Norton Community Hospital ("Norton") in Norton, Virginia, is a relatively small acute care hospital with only 129 beds and approximately 300 employees. The United Steelworkers, Local 14459, represents two bargaining units at Norton: a nonprofessional unit comprised of licensed practical nurses, nurses' assistants, dieticians,

business office staff, and service and maintenance employees; and a professional unit which includes registered nurses and microbiologists. The cost of negotiating with Local 14459 substantially increases Norton's overall operational costs. Although the same union represents both of Norton's bargaining units, the contracts are negotiated separately and terminate at different times. Even though Norton's relationship with the Steelworkers spans approximately 30 years, negotiations often require at least 15 sessions with each session lasting an average of six hours.

Preliminary preparations for the negotiation of either of Norton's contracts are also very time consuming and labor intense. The management negotiating team, which is comprised of four members from upper level management, meets with the managers of the hospital's departments and with the executive management staff to review difficulties arising in the administration of the current contract and solicits comments on provisions which may need to be included in the new agreement. The total time involved in such preparation is estimated to be approximately 240 hours. This estimate does not include clerical time involved in typing draft proposals or counter proposals.

In July 1990, employees at Dickenson County Medical Center ("Dickenson") in Clintwood, Virginia, voted for representation by the United Mine Workers of America ("UMWA"). Dickenson is a small hospital with only 50 beds employing 120 individuals, 100 of whom will now be represented by the union. The UMWA represents two units, a broad nonprofessional unit and a professional unit representing the registered nurses. It is anticipated that considerable time and resources will be expended to reach a contract agreement. Negotiations began with the UMWA following certification of the election results. The negotiations have been ongoing since that time and there have been a number of bargaining sessions between the hospital's negotiating team, which includes outside counsel, and the UMWA. At this time, a number of issues remain to be resolved.

In one sense, it is fortunate for Dickenson that its employees were organized prior to implementation of the Board's Final Rule. Under the Board's new Rule, the employees currently represented by the

UMWA might have been separated into six separate bargaining units.³ Such a fragmentation of the workforce would produce a serious disruption in the daily administration and operation of such a small hospital.

The Board's Final Rule with its provision for eight different bargaining units is potentially an administrative nightmare for all acute care hospitals. The effect of this Rule will not be limited to hospitals with pending representation petitions. Unions have uniformly expressed their renewed interest in organizing hospitals along the lines set forth in the Board's Rule. They have positioned themselves to take immediate advantage of the Rule's prescription for proliferation. The National Union of Hospital and Health Care Employees recently announced that it would triple its 28,000 member dues in order to finance a massive, nationwide organizing campaign in 1991. The union expects this Court to approve the Board's Final Rule and, in response, has decided that it will add 400 more organizers to undertake what the union calls "the largest mobilization for organizing ever undertaken by the American labor movement." 213 Daily Labor Report (BNA) at p. A-18 (11-2-90). The United Mine Workers' representative who organized Dickenson County Medical Center has bragged that his union would attempt to "organize everything we can here in Southwest Virginia." The Coalfield Progress, July 24, 1990, at 1, col. 1. Thus, hospitals can expect an immediate and substantial increase in union organizing activity among the separate employee groups which correspond to the eight bargaining units in the Final Rule.

C. The Board's Rule Is Arbitrary And Capricious Because It Applies To All Hospitals In Virginia Regardless Of Their Size And The Diversity Of Services Offered At Each Facility

The Board brushed aside the differences among acute care hospitals during its rulemaking proceeding by describing the differences in size and the variety of services offered as being merely "minor

³ The Board's Final Rule does allow for stipulated bargaining units which are not in accordance with the units specified in the Rule. 29 CFR § 103.30 (d). As a practical matter, however, no union will stipulate to a broader unit than that petitioned-for unless the union is confident of victory in a representation election involving the greater number of employees in the broader unit.

differences". See NPR II, 53 Fed. Reg. 33,932. Such a superficial assessment of modern health care institutions illustrates the Board's lack of insight into the actual operation and administration of different types of hospitals as well as its disregard for the specific needs which certain hospitals fulfill in a particular community. It is absurd to characterize the differences between large metropolitan hospitals, which have a complex, multi-facility operation and a variety of specialized service departments, and small rural hospitals, where administrators and employees alike fulfill several different job functions, as "minor". It is precisely the size of a hospital and the work being done within that hospital which helps create the community of interests shared by employees at any particular facility. The Board's decision to apply the Rule to all acute care hospitals regardless of size and the variety of services offered at each institution is arbitrary and capricious because it ignores two substantial factors contributing to the growth of common interests.

Member hospitals within the VHA vary from large metropolitan hospitals like Fairfax Hospital with 656 beds and over 4,600 employees to small rural hospitals like Bath County Community Hospital ("Bath County"), which has 25 beds and 85 employees. Fairfax Hospital has over 1,436 registered nurses in comparison to the 20 registered nurses employed at Bath County. Similarly, Richmond Memorial Hospital ("Richmond Memorial") in Richmond, Virginia, has 420 beds and 292 registered nurses, while St. Mary's Hospital ("St. Mary's") in Norton, Virginia, has 54 beds and 8 registered nurses.

The VHA is especially concerned about the potential harm that will be visited on small hospitals within the state if the Board's Rule is allowed to be implemented. Sixty percent of the acute care hospitals in Virginia are small hospitals with less than 200 beds. Twenty-five percent of the VHA's acute care hospital members have less than 100 beds. These hospitals are most vulnerable to the increase in costs that will be incurred as a result of the Board's Final Rule. Of hospitals with less than 100 beds in Virginia, forty-eight percent suffered operating losses in either 1988 or 1989. A small hospital simply cannot absorb the costs of having to negotiate and administer eight different contracts. Even one or two bargaining units may jeopardize

the welfare of small rural hospitals.⁴ For example, on the day the union claimed victory at Dickenson County Medical Center, only 12 of the hospital's 50 beds were occupied. The hospital's administrator believes that the cost of dealing with the union will bring additional financial hardship on an institution already struggling to survive. The Coalfield Progress, July 24, 1990, at 1, col. 3.

Size alone is not the only factor which must be considered in evaluating the community of interests likely to be present in a hospital workforce. The variety of medical services available in Virginia hospitals provides varied employment opportunities and experiences for health care professionals. Metropolitan hospitals like Fairfax Hospital, Roanoke Memorial Hospitals, and The Alexandria Hospital have a variety of specialized departments providing sophisticated care to patients with severe injuries and illnesses. Health care professionals working in these specialty departments may have more in common with each other than with similarly licensed professionals elsewhere in the hospital. The specialized nature of care in these departments requires greater integration in responding to patients' medical needs. For example, registered nurses assigned to the pediatric intensive care unit or the neonatal intensive care unit at Fairfax Hospital must work closely with social workers, physical therapists, occupational therapists, speech pathologists, and respiratory therapists in providing comprehensive treatment in these specialized areas. The high degree of specialization and intricacy of medical/surgical procedures used in the delivery of these services create an employment atmosphere conducive to the growth of a community of interests among the registered nurses and allied health professionals in these departments.

The Alexandria Hospital has a special cancer center in which registered nurses provide clinical expertise to patients undergoing various forms of cancer treatment. The center's staff includes a dosimetrist, a senior dosimetrist, radiation therapists, a simulation technician, registered nurses and social workers. All these employees not only work together and share similar working conditions but continuously confer with each other to ensure that treatment is effective. As a result, registered nurses in the cancer center are likely to

⁴ Perhaps not unexpectedly, all three unionized hospitals in Virginia experienced operating losses in either 1988 or 1989.

have more in common with other allied health professionals in the center than with registered nurses in other departments of the hospital.

Roanoke Memorial Hospitals ("Roanoke") has several specialty units which require registered nurses and allied health professionals to coordinate their services in providing patient care. Diabetic services at Roanoke utilizes registered nurses, licensed practical nurses, nurses' assistants, dieticians, social workers, physical therapists, occupational therapists, and medical technologists, in addressing the medical, social, and psychological needs of diabetic patients. Roanoke's neonatal care unit is staffed by registered nurses, licensed practical nurses, respiratory therapists, x-ray technicians, medical technologists and social workers.

There are many more examples of specialty units within Virginia hospitals where various health care professionals must coordinate their services to provide efficient and effective health care treatment. These examples undermine the basic assumption implicit in the Board's Final Rule, i.e., that all registered nurses working in a complex and multidisciplinary metropolitan hospital share similar interests and working conditions with other registered nurses throughout the facility and do not share common interests with other allied health professionals in the hospital.

On the other hand, smaller hospitals in Virginia also have unique characteristics which make the Board's *per se* rule arbitrary and capricious. For example, smaller facilities like Bath County Community Hospital and St. Mary's Hospital focus their efforts on providing quality primary care and general surgery services to the local community. These smaller rural hospitals do not have the resources to staff and equip sophisticated tertiary care units, but, instead, concentrate on stabilizing a severely injured patient until transfer to a more advanced unit is arranged. Because of this emphasis on primary care, these facilities do not have the diverse specialization among job functions found in the larger metropolitan facilities. Thus, registered nurses in these hospitals may, in fact, share similar duties. Equally true, however, is the fact that registered nurses in these smaller facilities also share duties with other employees or may, as part of their routine job responsibilities, be engaged in procedures for which larger hospitals employ special technical employees. For example, Culpeper

Memorial Hospital in Culpeper, Virginia employs phlebotomists and respiratory therapists but based on budgetary constraints and actual demand, these employees may not be scheduled for certain shifts. During these shifts, the registered nurse draws blood for any necessary laboratory samples and will adjust or apply ventilators for respiratory-dependent patients.

In addition, the division of functions between professionals, technicals and nonprofessionals in smaller hospitals often becomes blurred. For example, in Lonesome Pine Hospital, a 60-bed acute care hospital located in Big Stone Gap, Virginia, registered nurses act as unit secretaries; material management employees are involved in the clerical aspects of their position; and a licensed practical nurse in physical therapy does all the charting and typing of reports and forms.

The cooperation and interaction among staff in smaller hospitals extends throughout the hospitals. The focus in these facilities is on the common goal of providing competent health care. Therefore, registered nurses will assist office workers in completing administrative reports; office workers will help clean patient care units if the need arises; and housekeepers will stop cleaning, wash their hands, and fluff a patient's pillow. At Lonesome Pine, a registered nurse may have to clean rooms during the midnight shift as the need arises because no housekeeper is scheduled for that shift. The pharmacist at Lonesome Pine also supervises the material management staff as part of his duties. Pharmacy technicals are cross-trained in material management, and the material management staff may substitute as pharmacy technicals. This type of interaction among employees at small hospitals illustrates that the Final Rule is arbitrary and capricious in not recognizing that such special conditions may exist which make the Rule's mandated units inappropriate. Because the Rule's narrow extraordinary circumstances exception will not allow small hospitals to demonstrate the uniqueness of their facilities, the ability of these rural hospitals to operate efficiently and economically will be diminished.

D. The Board's Rule Is Arbitrary And Capricious Because It Ignores The Integration And Interaction Of Health Care Employees Within Virginia Hospitals

The health care industry is changing dramatically in Virginia and the Board's Rule provides no avenue for recognition of these changes. For example, the increasing use of outpatient clinics in providing both preventative medical services and minor surgery has contributed to the declining occupancy rates experienced by acute care hospitals. A natural outgrowth of this trend is that patients now admitted are more acutely and seriously ill than in the past. This obligates hospitals to restructure traditional methods of patient care to meet the more specific needs of their patients.

Many Virginia hospitals have responded to these changes by redesigning their approach to patient care in a manner which increases the integration of professionals and nonprofessionals in the workplace. Many hospitals have created specific mechanisms for increasing the coordination between care givers at their facilities. For example, many hospitals have begun utilizing interdisciplinary committees to resolve difficult medical problems relating to individual patients or simply to enhance patient care generally by planning for coordinated delivery of medical services to patients. These committees, which may be designated "patient care planning committees", "collaborative committees for patient care", or "interdisciplinary committees on patient care", provide a comprehensive approach to the medical, physical, emotional and psychological needs of a patient. The more complex patient care questions may be discussed during formalized "rounds" where an interdisciplinary group of professionals will discuss the more challenging patients under their care.

For example, The Alexandria Hospital utilizes an integrated patient care system. All service units hold meetings to coordinate patient care. Meetings are held weekly or more frequently depending on the need of the patients, and the attendees include dietitians, social workers, registered nurses, physicians and rehabilitation therapists assigned to a particular case. These meetings promote an exchange of information to enable the professional team to assess a patient's

present condition, reevaluate and alter treatment, or prepare the patient for discharge.

The increasing tendency of modern hospitals is to structure their organizations in a manner which promotes the integration of individual professionals and which better coordinates direct patient care services with support services. For example, hospitals are eliminating separate nursing divisions, and, instead, structuring hospital departments along service lines. National Hospital for Orthopaedics and Rehabilitation, located in Arlington, Virginia, has restructured its organization by joining nursing and ancillary services in a unified department known as Patient Care Services, managed by the Vice President, Patient Care Services. This structure improves the quality of patient care because one person is aware of difficulties encountered in all aspects of direct patient care and can move quickly should any problems arise. Additionally, the hospital can better assure that all aspects of its medical services reflect management's goal of a collaborative, integrated approach to patient care.

In light of such organizational changes, the Board's decision to segregate registered nurses in a separate bargaining unit is especially arbitrary and capricious. It is not uncommon for registered nurses to be working in laboratories with medical technologists, in cardiovascular services departments along side cardiovascular technologists, in "rehabilitation" units with physical therapists and occupational therapists, in "psych" units with mental health counselors and social workers, in radiology departments with x-ray technicians, or in utilization review departments where they interact with many different health care professionals.

There are other multidisciplinary committees being used in Virginia hospitals to fulfill various patient care and hospital operating goals, both routinely and on an *ad hoc* basis. For example, Franklin Memorial Hospital in Rocky Mount, Virginia, utilizes a multidisciplinary committee consisting of medical technologists, radiologic technologists, nurses, and a pharmacist to investigate improvements in the delivery of patient care and to develop a plan for implementation of proposed changes. Radford Community Hospital in Radford, Virginia, uses a "team treatment committee" in evaluating and determining the treatment modality for hospital patients requiring respiratory

treatment. This team, composed of a registered nurse, the attending physician and the respiratory therapist, performs joint reviews of patient care. The patient care evaluation committee at Gill Memorial Eye, Ear, Nose & Throat Hospital in Roanoke, Virginia, is responsible for reviewing all issues concerning patient care and the results of this meeting are reported to physicians for their monthly medical staff meetings. The committee is multidisciplinary with representatives of all departments serving on the committee.

A multidisciplinary committee, known as the professional advisory committee, is used in Giles Memorial Hospital in Pearisburg, Virginia to review the performance and conduct of its home health department. This department provides skilled nursing services and other personal care services in a patient's home. The professional advisory committee is composed of physicians, nursing representatives and physical therapists. Acute care hospitals which incorporate long-term or extended care within their facilities also use a multidisciplinary committee to develop and evaluate long-term patient care. For example, at Wythe County Community Hospital, in Wytheville, Virginia, a treatment planning committee meets regularly to discuss its long-term patients. The committee is comprised of physicians, nurses, social workers, discharge planners, dieticians and rehabilitation therapists. Psychiatric units in acute care hospitals also integrate professionals to enhance services. At St. Mary's Hospital, the patient care treatment team includes members of social services, quality assurance, utilization review, psychiatry and the recreational activities director. Under the supervision of the psychiatrist, this group meets one or two days a week and develops a complete plan of treatment, including outpatient care.

Not only is there increased integration among the different disciplines providing health care services as a result of collaborative concepts for patient care, but the very nature of modern health care requires heightened interaction between professionals. No longer is treatment provided only through the efforts of the attending physician and a nurse. During a patient's stay, he or she will be visited by therapists, technologists, and other technicals who provide treatment, run tests, operate sophisticated equipment, and ensure the equipment being used is performing properly. In addition, there is an increasing awareness that a patient's mental attitude regarding an illness is an

important component of recovery. Therefore, social workers and mental health counselors will talk with patients during and after their stay at a hospital.

Nutritional support is another key area where professionals frequently collaborate concerning the nutritional requirements of patients. Many hospitals are establishing formal nutritional support teams which combine the expertise of registered nurses, physicians, dieticians, and pharmacists to utilize nutritional support for enhancing and accelerating a patient's recovery.

Discharge planning has become a very common team concept for modern acute care hospitals. Discharge planning can take many variations. For example, Franklin Memorial's Hospital's discharge planning team is composed of nurses and social workers who meet three times a week to assess the needs of patients after discharge. St. Mary's Hospital's discharge planning department includes a social worker, a utilization review/quality assurance coordinator, the education director, home health services employees and registered nurses. Culpeper Memorial Hospital assigns a registered nurse to the discharge planning department who works with social workers to assist patients. In Bedford County Memorial Hospital in Bedford, Virginia, a social worker is responsible for developing the discharge plan but confers with attending physicians and registered nurses before finalizing the plan. Despite the varied procedural methods adopted by hospitals for discharge planning, all procedures usually require interaction among many different health care professionals, including registered nurses, social workers, rehabilitation therapists, pharmacists and physicians.

Other departments within acute care hospitals demonstrate the frequent interaction of health care professionals in modern facilities. Operating rooms and emergency rooms are common examples of departments where various specialists coordinate and combine their expertise to provide patient care. The Bedford County Memorial Hospital surgery room is a good example of coordinated medical services in a small facility. Nurses, medical technologists, medical lab technicians, respiratory therapists, radiologic technologists and anesthesiologists work together to treat emergency room patients at Bedford County. Nurses will get IVs started, change dressings and help the

physicians with suturing, while medical technologists and medical lab technicians come to the emergency room to run lab tests or draw blood. If the patient has respiratory distress, the respiratory therapist will put the patient on a respirator. In addition, x-ray personnel use mobile, portable equipment to take x-rays of patients. Similarly, at Stonewall Jackson Hospital's emergency room, registered nurses administer medication to patients and assist physicians while medical laboratory technicians draw blood and analyze specimens, respiratory therapists ventilate patients who have cardiac arrest and radiology technologists confirm the placement of ventilation tubes. These coordinated systems for delivering emergency care are repeated throughout other Virginia hospitals.

Operating rooms have always been a model for teamwork within hospitals. All hospitals maximize the coordination of professionals and technical personnel during surgery to achieve efficient yet careful surgical procedures. For example, Mount Vernon Hospital in Alexandria, Virginia, utilizes a "surgical suite" to achieve an interdisciplinary approach to surgery with registered nurses, surgical technicians, physicians, and physicians' assistants working together to deliver quality health care.

The integration and interaction of health care professionals in modern acute care hospitals are very important factors that should be explored by the Board before using an arbitrary bargaining unit to separate registered nurses from other health care professionals in an otherwise integrated workplace. A case by case adjudication of appropriate bargaining units would reveal that health care professionals in Virginia hospitals participate in common benefit plans and work under uniform personnel policies. They have comparable salaries, receive identical bonus pay, work similar schedules, and receive identical shift differential. Interdisciplinary training is accomplished through other collaborative practice groups. Health care professionals may give in-service training to each other in their respective specialties. Interaction of employees is stimulated further by training or educational sessions on more generic subjects such as infection control, CPR training, stress management, hazard abatement, or EAP opportunities.

This team approach to patient care that is prevalent throughout many Virginia hospitals will clearly be disrupted by the *per se* application of the Board's Final Rule. The Final Rule forces professionals working on the same hospital team into separate units for bargaining. The Rule also increases the likelihood that these professionals will be represented by different unions. Conflicting work rules regarding hours of work, overtime and other working conditions are likely to destroy the cohesion fostered by each hospital's integrated approach to patient care. Ultimately, patient care may be impaired by conflict between union members, thereby creating the very situation which Congress attempted to avert in drafting the Health Care Amendments Act and instructing the NLRB to avoid proliferation.

IV. CONCLUSION

For all the foregoing reasons, and for the reasons stated in the brief of the America Hospital Association, the decision of the Seventh Circuit should be reversed.

Respectfully submitted,

By: _____

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APPENDIX

**U.S. Department of Justice
Office of the Solicitor General**

October 24, 1990

John G. Kruchko
Kruchko & Fries
Counselors at Law
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*
No. 90-97

Dear Mr. Kruchko:

In response to your letter of October 23, 1990 I hereby consent to the filing in the above-captioned case of an *amicus curiae* brief on behalf of the Virginia Hospital Association.

Sincerely,

/s/ Kenneth W. Starr

Solicitor General

2a

DICKSTEIN, SHAPIRO & MORIN

October 24, 1990

John G. Kruchko, Esquire
Kruchko & Fries
7929 Westpark Drive
Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. N.L.R.B.*, et al.
No. 90-97

Dear Mr. Kruchko:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of the Virginia Hospital Association.

Sincerely,

/s/ Woody N. Peterson

WNP: hmp

3a

MAYER, BROWN & PLATT

October 17, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*

Dear Mr. Lusky:

On behalf of the American Hospital Association, I hereby consent to the filing of a brief *amicus curiae* by the Fairfax Hospital System, et al. in the above-referenced case.

Sincerely,

/s/ James D. Holzhauser

JDH: cml

**AMERICAN FEDERATION
OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS**

Ocotber 29, 1990

Mr. John G. Kruchko
Mr. Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Dear Messrs. Kruchko & Lusky:

Re: *American Hospital Association v. N.L.R.B.*,
et al. (Supreme Court No. 90-97)

The American Federation of Labor and Congress of Industrial Organizations hereby consents to the timely filing of an amicus curiae brief in support of the petitioner in the above-referenced matter on behalf of the Maryland and Virginia Hospital Associations.

Sincerely yours,

/s/ David M. Silberman

Associate General Counsel

(16)
No. 90-97

Supreme Court, U.S.
FILED

NOV 21 1990

JOSEPH E. SPANIOLO, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
PETITIONER

v.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
RESPONDENTS

**On Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit**

**BRIEF AMICUS CURIAE OF WILLIAM BEAUMONT
HOSPITAL, HENRY FORD HOSPITAL, ST. JOHN
HOSPITAL AND MEDICAL CENTER, AND
THE MICHIGAN HOSPITAL ASSOCIATION
IN SUPPORT OF THE PETITIONER**

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No. 90-97

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OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
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HOSPITAL, HENRY FORD HOSPITAL, ST. JOHN
HOSPITAL AND MEDICAL CENTER, AND
THE MICHIGAN HOSPITAL ASSOCIATION
IN SUPPORT OF THE PETITIONER**

William Beaumont Hospital, Henry Ford Hospital, St. John Hospital and Medical Center, and the Michigan Hospital Association respectfully submit this *amicus curiae* brief in support of Petitioner American Hospital Association.¹

INTEREST OF THE AMICI CURIAE

The three individual hospitals submitting this *amicus curiae* brief — William Beaumont Hospital, Henry Ford Hospital, and St. John Hospital and Medical Center — are among the largest and most diversified acute care hospitals in the state of Michigan.

¹ The written consent of each of the parties to the filing of this brief has been filed with the Court.

Located in metropolitan Detroit, these three hospitals account for nearly 20 percent of all hospital admissions in southeastern Michigan. They collectively employ nearly 20,000 individuals at their primary hospital locations and at numerous medical centers and satellite facilities throughout the Detroit metropolitan area. With only the remotest of exception (largely involving guards), the workforces of these hospitals have not been organized by labor unions.

The fourth *amicus curiae*, the Michigan Hospital Association, is a voluntary non-profit membership corporation consisting of 209 organizations that provide critical health care services to the 9,000,000 citizens of Michigan. Member facilities range in size from the 15-bed 379th Strategic Hospital at the Wurtsmith Air Force Base to the 960-bed Henry Ford Hospital in downtown Detroit. Approximately one-half of the Association's members are small institutions having fewer than 100 beds; most of these are located in rural areas of Michigan where they serve as the primary providers of health care services in their communities. The other half of the Association's members serve the various urban areas of the state.

The three individual hospitals submitting this *amicus* brief, and a substantial number of the Association's other members, are deeply affected by the National Labor Relations Board's promulgation through rulemaking of a virtually *conclusive presumption* that eight collective bargaining units are appropriate for them and for all other acute care hospitals throughout the United States. The Board's rule is predicated on a fundamentally mistaken "empirical" premise: that all acute care hospitals are the same, as if fashioned from a single cookie cutter, regardless of their substantial differences in mission, location, size, organizational structure, staffing patterns, and the like. The Board's rule purports to treat all hospitals according to a least-common-denominator model without any pretense of giving consideration to the unique characteristics of each hospital — uniquenesses that are illustrated by the hospitals and Association members submitting this brief.

Due to the legal infirmities of the Board's rule, which will have significant ramifications for acute care hospitals in Michigan and elsewhere, *amici curiae* respectfully urge the Court to declare that the Board's rule was improperly promulgated and cannot be applied.

INTRODUCTION AND SUMMARY OF ARGUMENT

At first blush the Board's rule prescribing eight units for all acute care hospitals throughout the country may appear to be an efficient and sensible way of creating predictability and minimizing litigation in this important field. It becomes clear upon closer scrutiny, however, that the Board's rule has several severe defects requiring its invalidation.

Perhaps most remarkably, the Board's rule flies in the face of the National Labor Relations Act's own language, which in Section 9(b) requires that bargaining unit determinations be made "in each case." The explanations given by the Board for effectively erasing this language from the Act do not survive analysis. The Act clearly requires the Board to conduct case-by-case adjudications to determine appropriate bargaining units in this and every other industry — thereby taking into account the unique characteristics of particular employers and their employee groupings.

The Board's rule also disregards the congressional admonition against proliferation of bargaining units in the health care industry. While the Board suggests that the eight units prescribed for acute care hospitals in the rule are not *that many* more than the three-unit statutory minimum, or the six-unit configuration the Board proposed at the outset of its rulemaking proceeding, the addition of even one or two more bargaining units — *and these are the units likely to become organized* — causes undue proliferation and the potential for all of the disruptive consequences feared by Congress when the Act was amended in 1974. The Board is seeking to accomplish through rulemaking the very same

result that the courts have repeatedly struck down in adjudicated cases as violative of the congressional admonition.

The Board's rule is also arbitrary and capricious. It presumes that alleged "empirical" evidence *generally* applicable to the hospital industry may legally surmount *particularized* evidence concerning the structure and operations of a specific hospital. As the Board's own prior adjudicatory decisions show, there are wide variations within this rapidly evolving industry that require flexibility in unit determinations. The rule conclusively prohibits this flexibility. In the interest of supposed efficiency, the rule deprives hospitals of their constitutional right to be heard.

Underlying the Board's rulemaking is its unwarranted belief that Congress was simply wrong when it expressed concern in 1974 over work stoppages, jurisdictional disputes, whipsawing, and leapfrogging in the health care industry. Those were then, and are still, real and legitimate concerns for individual hospitals and for the industry as a whole. The Board has effectively overruled Congress' concern. The Seventh Circuit's decision vacating the district court's injunction should be reversed.

ARGUMENT

I. Section 9(b)'s "In Each Case" Requirement Mandates Individual Bargaining Unit Determinations

In its First and Second Notices of Proposed Rulemaking, and in promulgating its Final Rule, the Board considered but rejected the argument raised by commentators that it is improper for the Board affirmatively to prescribe *substantive bargaining units* for a class of employers through rulemaking.¹ NPR I, 52 Fed.Reg. 25144-25145; NPR II, 53 Fed.Reg. 33901; Final Rule, 54 Fed.Reg. 16338. The Board acknowledged that this is the Board's "first venture in major, substantive rulemaking," *id.* at 16339, inasmuch as its prior rulemaking had involved non-substantive procedural or jurisdictional matters applicable to cases generally.

One Board Member, Wilford W. Johansen, dissented from the Board majority's conclusion that Section 9(b)'s "in each case" requirement permits this type of substantive bargaining unit rulemaking. NPR II, 53 Fed.Reg. 33935; 54 Fed.Reg. 16347. Eight years earlier, a differently composed Board had adopted what has now apparently become the dissenting view. In *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), the Board held that the "in each case" requirement of Section 9(b) precluded any *per se* approach to unit determinations. Two years later, in *St. Francis Hospital I*, 265 NLRB 1025, 1028 (1982), the Board reaffirmed the view that Section 9(b)'s "in each case" requirement mandated case-by-case adjudication; and it did so again in *St. Francis Hospital II*, 271 NLRB 948, 954 (1984) ("[N]o unit is *per se* appropriate and . . . separate representation must be justified upon each factual record . . .").

What rational explanation has the Board presented for its abruptly changed view of the Act's "in each case" requirement? The Board has essentially stated three reasons, but none withstands scrutiny.

First, the Board majority has extensively relied on language from Kenneth Culp Davis' *Administrative Law Text* 145 (3d ed. 1972) that Section 9(b)'s "in each case" requirement

does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents.

NPR I, 52 Fed.Reg. 25144; NPR II, 53 Fed.Reg. 33901; see also Final Rule, 54 Fed.Reg. 16338.² Beyond that, the Board majority notes that "[i]t has long been the Board's practice to formulate 'rules' to guide it in representation matters," including contract

² Davis' *Administrative Law Text* is a law student hornbook. *Id.* at III. The quoted comment concerning the Act's "in each case" requirement does not appear in Davis' subsequent treatises, which more broadly discuss the Board's rulemaking power. See, e.g., 2 Davis, *Administrative Law Treatise* §7:25 (1979).

bar rules, voter eligibility list requirements, and the like. NPR II, 53 Fed.Reg. 33901.

The shortcoming in the Board majority's reasoning is that Davis' comment was not referring to *substantive rules affirmatively prescribing universally appropriate bargaining units for an entire industry*. Davis was referring instead to "classifying problems, . . . developing rules or principles, . . . or relying on precedent cases which establish narrow or broad propositions." *Administrative Law Text, supra*. What the Board has now done is a far cry from establishing those types of general groundrules (exemplified by the contract bar rule and voting eligibility list requirement), which merely define the playing field on which representation questions will be determined. The Board's rule instead decides in advance the outcome of the game. It is a remarkable stretch of logic to suggest, as the Board majority does, that Davis' comment or the Board's own prior rulemaking can legitimize the instant rule. The dissenting Board Member properly rejected this justification.

The Board secondly contends that this Court's decision in *Heckler v. Campbell*, 461 U.S. 458 (1983), a case addressing the Social Security Administration's "grid" method of determining disability benefit entitlements, supports the Board's substantive unit determinations for the hospital industry. But *Heckler* provides no support at all, and indeed counsels the contrary. This Court there held that an "agency may rely on its rulemaking authority to determine issues that do *not* require case-by-case consideration." *Id.* at 467 (emphasis added). Here the Board is obligated by Section 9(b) of the Act to make a unit determination "in each case." What is more, *Heckler* held that the Secretary was required to make "findings on the basis of evidence adduced at a hearing" with regard to a claimant's individual abilities and qualifications, and that the Secretary could utilize rulemaking *only* for determining "an issue that is not unique to each claimant." *Id.* at 467-468. It is this portion of the *Heckler* decision that applies here.

There may be historical or statistical information regarding hospitals — analogous to the national employment and economic information in *Heckler* — that the Board could properly assimilate into a representation case's hearing record through rulemaking. But the existence *vel non* of distinct and appropriate bargaining units in a particular hospital is unquestionably an issue that is "unique" to that hospital.

Third, the Board asserts that, notwithstanding its eight-unit rule, an acute care hospital will always be permitted a hearing in a representation case and that a hospital can in any event invoke the "extraordinary circumstances" exception if its own unique characteristics do not fit the mold of the rule. Final Rule, 54 Fed.Reg. 16338 and n.2. These offerings by the Board ring hollow. If the Board had been serious about this, it would have crafted a rule containing *rebuttable*, rather than virtually *irrebuttable*, presumptions of appropriate units; the Board rejected that option as unnecessary and inefficient. NPR I, 52 Fed.Reg. 25145; Final Rule, 54 Fed.Reg. 16338-16339. It could not be clearer that the Board does not want individualized hearings on hospital bargaining units. Only evidence concerning ancillary issues — not related to appropriate units — could be presented by a hospital in a representation hearing. Final Rule, 54 Fed.Reg. 16338. And the "extraordinary circumstances" exception has been repeatedly described by the Board as so narrow as to banish it from existence. NPR I, 52 Fed.Reg. 25145; NPR II, 53 Fed.Reg. 33932. The Board's catalog of factual "variations in acute care hospitals" that will *not* be considered under the "extraordinary circumstances" exception (*id.*) is so comprehensive as to render it meaningless. That exception surely cannot be held out by the Board as a cure-all either for the rule's disregard of Section 9(b)'s "in each case" requirement or for its deprivation of procedural due process (discussed in more detail below).

There can be no doubt that the purpose and effect of the Board's rule mandating eight bargaining units in all acute care hospitals is to eliminate, once and for all, unit determinations "in each case." That result not only runs afoul of Section 9(b), but is

at odds with decisions of this Court addressing NLRB unit determinations. Section 9(b)'s "in each case" requirement has remained unchanged since 1935. As early as 1944 the Court observed that "the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit," and that Congress had therefore directed the Board to determine appropriate units on a case-by-case basis. *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944). A few years later, in *Packard Motor Co. v. NLRB*, 330 U.S. 485, 491 (1947), the Court again emphasized that "[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision." These principles have not changed.

Apart from the Seventh Circuit's decision below, other Courts of Appeals have recognized that *per se* approaches by the Board to unit determinations are violative of Section 9(b)'s "in each case" requirement.³ The Seventh Circuit's decision upholding the Board's rule should be reversed on this ground.

II. The Board's Rule Is Precluded By The Congressional Admonition Against Proliferation Of Bargaining Units In The Health Care Industry

Much debate has focused over the past 15 years on the weight and meaning to be ascribed to the admonition contained in the House and Senate Reports to the Health Care Amendments Act of 1974 that the Board give "[d]ue consideration . . . to preventing proliferation of bargaining units in the health care industry." S.Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R.Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). The Seventh Circuit's decision below, holding the congressional ad-

³ See, e.g., *Big Y Foods, Inc. v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981); *Long Island College Hospital v. NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), cert. denied, 435 U.S. 896 (1978); *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 638 (2d Cir. 1983); *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 360 (3d Cir. 1976); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979).

monition entitled only to "respectful consideration," runs directly against the current of prior Court of Appeals decisions which have given the admonition controlling weight in rejecting Board unit determinations.⁴

When the Board initially undertook hospital unit determinations after the 1974 amendments, it generally found eight units appropriate — just as the present rule does. This formulation met with little success in the Courts of Appeals,⁵ primarily for the reason that those units failed to comport with the congressional admonition. The Board then reconsidered its overall approach to hospital units. In *St. Francis Hospital II*, 271 NLRB 948 (1984), the Board formulated a new standard, moving from a "community of interests" test that generally produced eight appropriate units in a hospital to a "disparity of interests" test that generally produced five units, stating:

With the benefit of many years of thoughtful and often conflicting analyses among the Board members, courts of appeals, and legal commentators, we have formulated a revised health care employee unit approach which we believe will fulfill our dual obligations of adhering to the legislative intent behind enactment of the 1974 health care amendments to the Act and guaranteeing the representational interests of health care employees.

271 NLRB at 948 (footnote omitted).

⁴ See *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, supra, 699 F.2d 626, 638 (2d Cir. 1983); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 416 (9th Cir. 1979); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981). But see *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697, 712 (D.C. Cir. 1987), which found the congressional admonition essentially meaningless because it was never incorporated into the Act itself.

⁵ See, e.g., *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

"After careful and thorough consideration," the Board continued in *St. Francis II*, its Members were "persuaded" that the earlier approach was "contrary to the intent of Congress" and that "the adoption of a disparity-of-interests tests can best effectuate our statutory obligations in health care unit determinations" *Id.* at 950. Furthermore, "Congress clearly intended that, in determining appropriate units in the health care area, the Board should apply a stricter standard than its traditional community-of-interest analysis." *Id.* at 951.

The eight-unit formulation found in the Board's rule today is no different than the eight-unit formulation (utilized prior to *St. Francis II*) which had been rejected by many Courts of Appeals (and the Board itself in *St. Francis II*) as inconsistent with the congressional admonition. The only notable difference is that the Board's new rule purports to be based on "empirical" evidence regarding the health care industry as a whole, rather than on an evidentiary record compiled in a single adjudicatory proceeding; and it purports to govern an entire industry rather than a single hospital.

Thus, there is no dispute that the Board is attempting to accomplish through "empirical" rulemaking exactly what the courts have forbidden as violative of the congressional admonition — an eight-unit configuration for hospitals. Anomalously, the Board has taken this across-the-board approach in the *only* industry for which Congress expressed concern that the Board act with special care in determining units. No other class of employers has been singled out by the Board for the mandatory establishment of bargaining units without any regard to the configuration of their particular operations.⁶

⁶ The Board has repeatedly emphasized throughout the rulemaking proceedings that, even though its rule provides for eight separate bargaining units, it is unusual that a hospital would actually be organized to this extent by labor unions. NPR II, 53 Fed.Reg. 33908, 33909, 33910, 33923, 33933, 33934; Final Rule, 54 Fed.Reg. 16346. This misses the relevant point, however, because the Board's rule makes it an inevitability that there would be eight separate units in the event unions sought to organize them. And the advance subdividing of the work force would facilitate such organizing. It is thus illogical for the Board to

In summary, in conjunction with Section 9(b)'s "in each case" requirement, the congressional admonition mandates that the Board conduct case-by-case adjudications to determine appropriate bargaining units in the health care industry — no less than it does in all other industries — and in so doing to avoid unit proliferation at each hospital. The Board's rule is the very antithesis of this mandate, because it prescribes that every acute care hospital will have eight bargaining units.⁷ The Seventh Circuit's decision upholding the Board's rule notwithstanding the congressional admonition should be reversed for this reason as well.

III. The Board's Rule Is Arbitrary And Capricious

The Board has acknowledged that it engaged in this rulemaking because the courts rejected its prior approach to health care bargaining units:

Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.

suggest that the *presently* incomplete state of union organization mitigates the violence its rule does to the congressional admonition against proliferation.

Ironically, the Board states in NPR II that proliferation is relieved by the fact that guard units are "rarely sought" (53 Fed.Reg. 33934). It is precisely those units that have been organized at the three hospitals submitting this brief.

⁷ The Board itself increased the number of mandatory units at acute care hospitals from six in NPR I (52 Fed.Reg. 25149) to eight in NPR II (53 Fed.Reg. 33934), conclusorily stating in NPR II that the addition of these two units (skilled maintenance and business office clericals) did not produce a proliferation of bargaining units (53 Fed.Reg. 33923, 33926). The Board noted that 23 conceivable bargaining units (and perhaps an equal number of additional units) could *theoretically* arise in any single establishment, and that it is in any event "unlikely that all eight potential appropriate units will occur in any given hospital" (54 Fed.Reg. 16346). Needless to say, these statistics and predictions are of no solace to hospitals for whom the proliferation of even one or two additional units can have major consequence.

NPR I, 52 Fed.Reg. 25143.⁸

But why should a result achieved through rulemaking succeed where the identical result achieved through adjudication had failed? The Board's rule rests on the mistaken notion that "empirical" evidence concerning the hospital industry *generally* can legitimize a result (eight *per se* appropriate units) that has been and would be struck down in an adjudicatory proceeding.

The fundamental problem with the Board's approach is highlighted by this Court's decision in *Heckler v. Campbell*, *supra*. Just as individual Social Security disability claimants' qualifications required individual hearings as to their unique facts in *Heckler*, acute care hospitals are also sufficiently unique in mission, location, size, organizational structure, staffing patterns, and the like, to require individualized hearings concerning appropriate bargaining units. Individual hospitals are not fungible, nor are they mere statistics. It is wrong for the Board to declare by rule or fiat that they are.

This error pervades the Board's rulemaking. NPR II repeatedly acknowledges that the Board has based its rule on generalized least-common-denominator evidence and has purposefully ignored deviations from the general pattern at particular hospitals. A single but dramatic example concerns the use by some hospitals of special multi-disciplinary teams. The Board emphasizes that "the *weight* of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used

⁸ The Board initiated the rulemaking process in apparent reaction to the D.C. Circuit's decision in *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. 1987), holding (as no other Circuit had) that the Board had *improperly* concluded that the congressional admonition mandated a "disparity of interests" test for hospital bargaining units. The D.C. Circuit also held, however, that the Board possessed discretion to adopt a "disparity of interests" test, and expressed no view as to what test the Board should embrace in the exercise of its discretion. *Id.* at 699, 708 n.37, 711-712 n.65. See also *St. Vincent Hospital*, 285 NLRB 365, 367 (1987). Nothing precluded the Board from continuing to adhere to the "disparity of interests" test notwithstanding the D.C. Circuit's decision in *IBEW v. NLRB*, as the Board chose to do in *St. Vincent Hospital*.

within hospitals," and that "*fewer than half*" of the hospitals studied used special multi-disciplinary teams while "[s]ome hospitals do not utilize the team concept at all." NPR II, 53 Fed.Reg. 33907 (emphasis added). What the Board chooses to overlook is that *many hospitals do use special multi-disciplinary teams, in a fashion that removes them from the mainstream and warrants consideration of a different bargaining unit structure*. There are many other examples in NPR II of individual variations being dismissed by the Board in favor of the "typical," "normal," or "general" characteristics of hospitals. It is nevertheless indisputable that some hospitals do not fit the Board's mold.⁹

The arbitrariness of the Board's rule can also be seen in its treatment of *its own prior decisions* holding inappropriate, on the unique facts presented in those adjudications, the very bargaining units its rule would today declare universally appropriate. In *St. Vincent Hospital*, 285 NLRB 365 (1987), the Board held on the basis of an adjudicatory record that a separate registered nurses unit was inappropriate at that hospital because of the hospital's particular organizational structure, personnel policies, integration of employees, and other factors unique to it. The Board's rule now decrees that a separate registered nurses unit is universally appropriate regardless of such evidence. How can that be? The Board has sought to harmonize this inconsistency as follows:

Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations. . . . [W]ere we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

NPR II, 53 Fed.Reg. 33916.

⁹ That the Board will permit non-conforming stipulations (NPR II, 53 Fed.Reg. 33931) also demonstrates that some hospitals are sufficiently far from the "normal" or "typical" configuration as to warrant different treatment.

The Board has used the same sleight-of-hand for a separate skilled maintenance unit, which the Board had held inappropriate on the factual record in *St. Francis Hospital III*, 286 NLRB 1305 (1987), see NPR II, 53 Fed.Reg. 33923; and a separate business office clerical unit, which it had held inappropriate on the factual record in *Baker Hospital*, 279 NLRB 308 (1986), see NPR II, 52 Fed.Reg. 33926. Regardless of a particular hospital's configuration of these employee groupings, skilled maintenance and business office clerical units are now declared universally appropriate. The Board's cavalier "about-face" on these key units demonstrates the new rule's arbitrariness, as the Board has hardly supplied the requisite "reasoned analysis for the change." *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual*, 463 U.S. 29, 42 (1983).

The rule's arbitrariness is further shown by its failure to allow for any evidentiary consideration of the unique characteristics of large and diversified acute care hospitals (such as those submitting this *amicus* brief) and the ramifications of those characteristics on unit determinations. The delivery of health services is rapidly evolving. What is "empirically" typical in the industry today may be aberrational tomorrow. The Board's rule permits no accounting for this.

Many large urban hospitals now operate through an integrated network of dispersed medical centers and other facilities that comprise a single hospital system. Indeed, some have several geographically separate "campuses," but may well share employees, administrative services, and patients. Depending on a particular hospital system's organization, various locations may, or may not, have employees with identical interests, working conditions, supervision, and the like. It would be arbitrary indeed for a rule to presume irrebuttably (as the Board's rule evidently does) that such an organizational and geographic structure must be disregarded, and that only contiguous facilities be considered, in assigning the eight bargaining units decreed by the rule. See NPR II, 53 Fed.Reg. 33932.

By like token, the Board's rule allows no differentiation for the uniqueness of the many smaller and rural hospitals that comprise approximately one-half of the Michigan Hospital Association's membership. Those smaller and rural hospitals have dramatically different organizational structures and staffing patterns to reflect the lesser size and complexity of the institution. But the Board's rule fictitiously treats all acute care hospitals as though they are the same — whether they have 8,000 employees or just 80. The rule arbitrarily denies a hospital's right to adduce evidence regarding its own uniqueness or differentiation from the Board's perceived pattern. This denial raises important procedural due process concerns as well. See, e.g., *Cleveland Board of Education v. Loudermill*, 470 U.S. 532, 542-546 (1985); *Greene v. McElroy*, 360 U.S. 474 (1959).

As a final matter, the Board's second-guessing of Congress' concern in 1974 about proliferation of units in the health care industry is itself evidence of arbitrariness. The Board suggests in its Final Rule that Congress' articulated fear of work stoppages, jurisdictional disputes, wage whipsawing, and leapfrogging in the health care industry was unfounded because "multiple units have not been shown to cause an unusual number of work stoppages, nor that have they been shown to have caused jurisdictional disputes, wage whipsawing, or leapfrogging. . . . [T]here were virtually none of the disruptive consequences which concerned Congress during the 1974 debates" (54 Fed.Reg. 16346). The Board's logic misses the point that the courts have not tolerated proliferation of bargaining units in the hospital industry. The courts have rejected the eight units prescribed by the Board in its early decisions. These are the same eight units as those now prescribed in the rule. The evils feared by Congress have not been permitted to occur, as well they might if the Board's rule were now allowed to take effect.

CONCLUSION

The Seventh Circuit's decision upholding the Board's rule should be reversed and the district court's injunction should be reinstated.

Respectfully submitted,

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No. 90-97

In The
Supreme Court of the United States
October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,
vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
Respondents.

On Writ Of Certiorari To The United
States Court Of Appeals For The
Seventh Circuit

BRIEF OF THE MISSOURI HOSPITAL
ASSOCIATION AS *AMICUS CURIAE* IN
SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF THE MISSOURI HOSPITAL ASSOCIATION AS *AMICUS CURIAE*

This brief is submitted on behalf of the Missouri Hospital Association ("MHA") in support of petitioner, the American Hospital Association ("AHA"). The Missouri Hospital Association was an active participant in the National Labor Relations Board ("Board") hearings concerning the promulgation of the rule governing collective bargaining units in the health care industry. The MHA offered testimony through two of its leading health care executives and submitted written comments to the Board. The MHA also participated as an *amicus curiae* before the court of appeals for the Seventh Circuit and before this Court in support of the AHA's petition.

The MHA has 140 acute-care hospital members, representing ninety-eight percent of the acute-care hospitals in the state of Missouri.¹ The membership of the MHA ranges from large tertiary-care referral centers in major metropolitan areas to very small primary-care hospitals in rural areas. The diversity of the MHA membership and the general diversity of the health care industry in Missouri are of particular relevance to the issues presented to

¹ All statistical information concerning MHA member hospitals cited herein appears in *Missouri Hospital Profiles 1989*, a publication of the Missouri Department of Health, State Center for Health Statistics. The acute-care hospital figures exclude federal and state facilities, but include thirty-nine hospitals owned or operated by local governmental entities. This case is of interest to such governmental hospitals because the Missouri state agency having jurisdiction to establish bargaining units for them normally follows procedures adopted by the Board.

this Court by the AHA. The majority of the MHA's member hospitals are health care industry employers subject to the rule promulgated by the Board. As such they and the patients they serve have a significant and direct interest in the outcome of this case.

The MHA agrees with the AHA's legal position that the rule promulgated by the Board violates both the mandate of Section 9(b) of the National Labor Relations Act (the "Labor Act") that bargaining unit determinations be made "in each case," and the Congressional admonition against undue proliferation of bargaining units in the health care industry, contained in the legislative history of the 1974 Health Care Amendments to the Labor Act. The MHA relies upon the arguments made by the AHA in support of those positions. The MHA, as *amicus*, will not restate those arguments but will focus on Missouri's experience and demonstrate 1) the necessity of individualized bargaining unit determinations in light of the diverse and rapidly changing health care industry and 2) the proliferation of bargaining units in acute-care hospitals that necessarily will follow adoption of the rule.

The Board has concluded that acute-care hospitals display no differences relevant to bargaining unit determinations. The MHA finds this conclusion to be incredible and irrational in light of the wide range of hospital organizations and their relationships with their employees. In this regard, Missouri is a microcosm of the country, with major metropolitan hospitals at one end of the spectrum and small rural hospitals at the other. The MHA, as the representative of the vast majority of Missouri hospitals, believes it has information relevant to

this court's consideration of the writ of certiorari to the United States Court of Appeals for the Seventh Circuit.

SUMMARY OF THE ARGUMENT

I. The National Labor Relations Act requires that the Board determine "in each case" the appropriate unit for the purposes of collective bargaining. 29 U.S.C. § 159(b). The Board, however, has chosen to shirk its statutory responsibility by promulgating an irrebuttable rule that mandates eight units for all acute-care hospitals. The Board's dismissal as "merely minor differences" all variations among acute-care hospitals is arbitrary, capricious, and violates Section 9(b) of the Act.

A. The variations among acute-care hospitals in Missouri, as elsewhere, are substantial and are relevant to the determination of appropriate bargaining units. Factors such as size, services provided, number and classifications of employees, and administrative structure affect the manner in which employees relate to one another. These factors affect the appropriate bargaining units for those employees. Acute-care hospitals in Missouri range in size from eighteen licensed beds to 1,208 licensed beds, from twenty-eight full-time employees to 5,262 full-time employees. Services provided by acute-care hospitals range from basic inpatient and outpatient services to multi-location outpatient facilities and home health agencies. The bargaining unit rule forbids consideration of all such relevant information.

B. The rule first proposed by the Board subdivided health care institutions into 1) large acute-care hospitals

(those with more than 100 beds), 2) small acute-care hospitals (those with 100 or fewer beds), and 3) nursing homes. The Board based its decision to deem four units appropriate in small hospitals and six units appropriate in large hospitals on the fact that there is less division of labor and specialization and more functional integration of employees in small hospitals than in large hospitals. In response to criticism from the hospital industry that the 100-bed distinction was inadequate recognition of the diversity of acute-care hospitals, and criticism from union representatives that bed size did not correlate well with staff size, the Board completely abandoned its attempt to recognize any differences among acute-care hospitals and proposed that eight units be deemed appropriate in all acute-care hospitals. The Board's response was arbitrary, capricious, and ignored both the Board's own experience and the evidence placed before it in the rulemaking proceedings.

The Board's rationale for excluding nursing homes, psychiatric and rehabilitation facilities from rulemaking applies with equal or greater force to excluding acute-care hospitals. The Board abandoned its initial attempt to include nursing homes in the rule, based on the incorrect conclusion that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." 53 Fed. Reg. at 33927. Hospitals in Missouri vary more in size and provide a far wider range of services than nursing homes. Fifty-one MHA member acute-care hospitals have separate skilled nursing units in addition to acute-care beds. Psychiatric and rehabilitation hospitals are excluded from the Board's rule, but psychiatric and rehabilitation units within acute-care hospitals

are not. The factors relied upon by the Board to exclude psychiatric hospitals are relevant to the determination of the appropriateness of a bargaining unit regardless of whether the psychiatric facility is independent or affiliated with an acute-care hospital.

II. The House and Senate Committee reports accompanying the 1974 amendments to the Act contained an admonition to the Board to prevent the proliferation of bargaining units in the health care industry. The rule promulgated by the Board ignores this admonition and requires the automatic fragmentation of acute-care hospital employees into eight separate units.

A. The eight-unit rule is a significant increase over the number of units deemed appropriate by the parties and by the Board in hospital elections in Missouri. In a 1986 election at a ninety-two bed acute-care hospital the union sought two units, one of professional employees and one of nonprofessional employees. In a 1980 election at a seventy-eight bed acute-care hospital the union sought and the Board allowed two units, one of all ambulance department employees and the other of all other hospital employees. To mandate eight units at facilities such as these is undue proliferation of bargaining units.

B. In a Missouri industry that is not subject to a Congressional admonition the Board has refused to allow skilled maintenance employees to be separated from the production and maintenance bargaining unit representing all employees. An aerospace contractor with 7,300 employees in 116 different job classifications ranging from janitors and food service employees to highly skilled technical employees has one bargaining unit. A

rule mandating eight units – including a skilled maintenance unit similar to the one rejected at the aerospace contractor – for acute-care hospitals, regardless of the particularized facts at hand, is undue proliferation of bargaining units in the health care industry.

ARGUMENT

I. SECTION 9(b) OF THE LABOR ACT AND THE DIVERSE AND RAPIDLY CHANGING HEALTH CARE INDUSTRY REQUIRE INDIVIDUALIZED BARGAINING UNIT DETERMINATIONS.

Section 9(b) of the Labor Act provides, in part, that:

The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof. . . .

29 U.S.C. § 159(b) (emphasis added). The mandate of this language is clear: the Board must determine the appropriateness of bargaining units on an individual basis, considering the particular facts in each case. The Board, by promulgating an essentially irrebuttable rule for determining bargaining units in acute-care hospitals, has shirked its statutory responsibility to conduct this factual review and make individual decisions in each case.

The Board's Final Rule provides that:

Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for

petitions filed pursuant to section 9(c)(1)(A)(i) or 9(C)(1)(B) of the National Labor Relations Act . . . :

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

Final Rule, 54 Fed. Reg. 16347-16348 (1989). The only specific example of an "extraordinary circumstance" given by the Board is "a unit of five or fewer employees." *Id.* at 16348. In the Supplementary Information accompanying the Final Rule the Board reaffirmed the narrow scope of the "extraordinary circumstances exception" as previously set forth in its Second Notice of Proposed Rulemaking ("NPR II"). *Id.* at 16345. In NPR II the Board, in addressing variations between acute-care hospitals, stated that:

The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor

differences, inherent in the industry due to the multiformity of individual constituent institutions.

NPR II, 53 Fed. Reg. 33900, 33932.² This sweeping dismissal of any further consideration of the diversity of acute-care hospitals as "merely minor differences" is a flagrant violation of the "in each case" requirement of Section 9(b) and flies in the face of any realistic analysis of the health care industry. The court of appeals decision upholding the validity of the bargaining unit rule also improperly dismissed the importance of the differences among acute-care hospitals.

² The Board provided the following enumeration of "minor differences" in acute-care hospitals:

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nationwide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building.

NPR II, 53 Fed. Reg. at 33932.

A. The Hospital Industry In Missouri, As Elsewhere, Is Diverse And Rapidly Changing.

The variations in the hospital industry in Missouri, as elsewhere, hardly can be considered "merely minor differences" as the Board concluded. The MHA submits that such variations are substantial and are relevant to the determination of bargaining units. The Board's rule is arbitrary and capricious in that it ignores any and all differences among acute-care hospitals. In support of its position, the MHA offers the following information concerning the diversity of the hospital industry in Missouri and the relevance of that diversity to the determination of appropriate bargaining units.

1. The Variations In Acute-Care Hospitals In Missouri Are Substantial.

There are 142 acute-care hospitals in Missouri, 140 of which are members of the MHA. Of the member hospitals, seventy-two are rural and sixty-seven are urban.³ The largest member hospital has 1,208 licensed beds and the smallest has eighteen licensed beds. The member hospital with the largest staff employs the equivalent of 5,262 full-time employees; the smallest employs twenty-eight. The number of full-time registered nurses employed by member hospitals ranges from 1,201 to three.

³ The terms "rural" and "urban" as used for purposes of MHA statistics are as defined in the Medicare Regulations at 42 C.F.R. § 412.62(f).

Forty-five member hospitals have "swing beds," i.e., beds which, pursuant to federal Medicare and Medicaid statutes and Missouri regulations, may be designated from time to time either as skilled nursing care beds or acute-care beds, at the discretion of the institution. Fifty-one member hospitals have Medicare-certified distinct part skilled nursing units which are nursing home type units operated within the hospitals' facilities.

The services provided by the MHA member hospitals, and their related organizations, also vary widely. Some member hospitals provide basic inpatient and outpatient general care services while others operate, often through subsidiary corporations, activities such as home health agencies, inpatient and outpatient psychiatric units, multi-location outpatient clinics, outpatient surgical facilities and rehabilitation facilities.

In addition to its diversity, the hospital industry in Missouri, as elsewhere, is rapidly changing. With increasing frequency, health care providers are consolidating facilities and services to maximize efficiency and resources. These consolidations are taking place through mergers, acquisitions, and joint ventures. Entire health care systems are merging and reorganizing their employees and delivery systems. At the same time health care providers in urban areas are expanding their facilities through the development of satellite locations to serve patients outside the area normally served by their primary hospitals. These changes in structure and services result in changes in the number, mix and organization of employees. An irrebuttable rule that sets bargaining units in concrete is inappropriate for the rapidly changing health care industry.

2. The Variations In Acute-Care Hospitals In Missouri Are Relevant To The Determination Of Bargaining Units.

Each type of hospital described above and, indeed, each hospital, has a different employee mix and a different administrative structure. They have different ratios of one type of employee to another and of all employees to patients as well as different levels of integration among various employee groups. It should not require evidence or hearings to conclude that the employees of a twenty-bed hospital in rural Missouri are organized in a different fashion than the employees of a 1200-bed hospital in metropolitan St. Louis, Missouri. The patient acuity levels are substantially higher at the latter institution than at the former. Generally speaking, the higher the acuity level of the particular institution, the more skills that must be brought to bear upon each patient's needs at the same time. Thus, the higher the acuity, the greater the functional integration of the many categories of employees needed to care for a single patient. On the other hand, the large urban institution, with thousands of employees, is more likely to be able to hire fairly narrow specialists and concentrate their responsibilities within their primary area of expertise while the small rural hospital, with far fewer employees, must ask each employee to wear more hats and fill more roles.

An example of the high level of integration of the various classifications of health care employees is found in one acute-care hospital in Kansas City, with only 240 staffed beds, where registered nurses work in fifteen departments and occupations outside the nursing department, where they serve as traditional staff nurses or

operating room nurses.⁴ These registered nurses work in utilization review, risk management, quality assessment, social services, education, a preferred provider organization, medical records, admitting, administration, outpatient clinics, radiation therapy, central services, DRG coordination and review employee health, infection control and the wellness clinic. At that institution, approximately ten percent of the nurses are in non-patient-care areas and only seventy percent are in traditional acute patient-care settings.⁵ Nonetheless, the Board would require all of these registered nurses from many different departments, who have virtually nothing in common with each other except their state licensure but a great deal in common with other employees with whom they work on a daily basis, to be lumped into a single bargaining unit separate from all other employees. Such a result confounds reason and arbitrarily ignores the fact that "in each case" and particularly in *this* case a different result is required.

When the Board makes a determination concerning the appropriate bargaining units at a given employer it considers how that institution functions. The Board treats a retail store with an attached warehouse differently than a retail store and a warehouse which are not attached to

⁴ See, Testimony of Dan H. Anderson, Supplemental Appendix of Plaintiff-Appellee submitted to the court of appeals for the Seventh Circuit at 482.

⁵ See, November 6, 1987 letter to counsel for American Federation of Labor and Congress of Industrial Organizations, also submitted to the Board as part of the administrative record.

each other. *Sears, Roebuck and Co.*, 191 NLRB 398 (1971). Thus, the bargaining unit configuration depends upon the business structure adopted by the employer. An analogy to the acute-care hospital setting would require consideration of factors such as whether the hospital also operates an outpatient department or skilled nursing facility and whether the employees interact or interchange. The bargaining unit rule promulgated by the Board forbids the consideration of all such relevant information.

Even absent express congressional admonition against unit proliferation, the Board has found in the public utility cases that the public's "immediate and direct interest in the uninterrupted maintenance of the essential services" required "a systemwide unit . . . in the public utility industry. . . ." *Baltimore Gas & Electric Co.*, 206 NLRB 199, 201 (1973), cited and followed in *New England Telephone Co.*, 280 NLRB 162, 164 (1986). The Board has been reluctant "to fragmentize a utility's operations" and has done so "only when there was compelling evidence" that the narrower unit "conformed to a well-defined administrative segment of the utility company's organization and could be established without undue disturbance to the company's ability to perform its necessary functions." *Baltimore Gas*, 206 NLRB at 201. These strong policy considerations apply with at least equal force to the health care industry, especially in the face of strong congressional intent which the Board so cavalierly ignored here. The Board's proposed rule ignores the well-defined administrative structures of health care providers and irrationally proposes eight units, each of which cuts across those structures.

More importantly, the rule will not even allow consideration of those factors.

B. The Board's Rule Is Arbitrary And Capricious In That It Ignores The Diversity Of Acute-Care Hospitals.

The Board's refusal to recognize the significance and relevance of the differences among acute-care hospitals is arbitrary and capricious. The Board's decision not to distinguish among acute-care hospitals is particularly illogical and inconsistent in light of the Board's reasons 1) for initially distinguishing between acute-care hospitals on the basis of size, 2) for exempting nursing homes from the impact of the bargaining unit rule, and 3) for excluding psychiatric and rehabilitation hospitals from the rule.

1. The Board's Decision To Treat All Acute-Care Hospitals Alike Is Arbitrary, Capricious And Not Based On Substantial Evidence.

On July 2, 1987 the Board issued its first Notice of Proposed Rulemaking and Notice of Hearing concerning collective bargaining units in the health care industry ("NPR I"; 52 Fed. Reg. 25142 *et seq.*). The original proposed rule applied differently to three categories of health care institutions: 1) large acute-care hospitals, 2) small acute-care hospitals, and 3) nursing homes. Large acute-care hospitals were defined as those with more than 100 patient beds. Small acute-care hospitals were defined as those with 100 or fewer patient beds. NPR I, 52 Fed. Reg. at 25149.

The Board proposed that six collective bargaining units be deemed appropriate in large acute-care hospitals: 1) registered nurses; 2) physicians; 3) other professional employees; 4) technical employees; 5) service, maintenance, and clerical employees; and 6) guards. NPR I, 52 Fed. Reg. at 25146-48. The Board proposed that four collective bargaining units be deemed appropriate in small acute-care hospitals and nursing homes: 1) all professional employees; 2) technical employees; 3) service, maintenance, and clerical employees; and 4) guards. NPR I, 52 Fed. Reg. at 25148. In explaining its decision to differentiate between large and small acute-care hospitals, the Board stated that:

[W]e think that in smaller facilities there will be found less division of labor and specialization, and more functional integration of employees' services, than normally is the case in large hospitals.

NPR I, 52 Fed. Reg. at 25148.

In its Second Notice of Proposed Rulemaking the Board abandoned the distinction between large and small acute-care hospitals. The Board stated that its decision to drop the 100-bed distinction was based on "the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term 'bed' in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the parties' general opposition to use of a distinction based on the number of beds." NPR II, 53 Fed. Reg. at 33927.

While it is true that the hospital industry in general, and the MHA in particular, criticized the 100-bed distinction, these criticisms were not based on either evidence or belief that all acute-care hospitals are alike. Quite to the contrary, the hospital industry criticized the 100-bed distinction because it did not describe or define accurately the differences among acute-care hospitals that are relevant to the determination of appropriate bargaining units. The MHA, both in oral testimony at the administrative hearings and in written comments submitted to the Board, criticized the 100-bed distinction as unreasonable because, among other reasons, (1) a 100-bed hospital is not a "large" hospital, and 2) the rule did not provide a definition of "bed." The MHA suggested that, if a rule was to be adopted, the bed standard should be based on occupied or staffed beds rather than licensed beds because many hospitals are licensed for more beds than are utilized. The MHA also suggested that small hospitals be defined as those with fewer than 400 staffed beds.

The Board's initial proposed rule recognized that there are differences among acute-care hospitals that are relevant to the determination of appropriate bargaining units. The Board observed that, based on its experience, "[i]n smaller facilities, it is likely that employees will have more contacts with one another, may to some extent perform one another's work, and generally may share interests more than groupings in larger hospitals." NPR I, 52 Fed. Reg. 15246. Instead of refining its rule in response to the criticism and evidence of the inadequacies of the proposed 100-bed distinction, however, the Board simply ignored all of its prior experience and relevant testimony, and abandoned its attempt to distinguish among acute-

care hospitals. This decision by the Board is arbitrary and capricious and is not based on substantial evidence.

The court of appeals for the Seventh Circuit recognized as "an important criticism" the hospital industry's position "that the Board's rule is arbitrary because it lumps together hospitals of different sizes and missions in different locations." *American Hospital Ass'n v. N.L.R.B.*, 899 F.2d 651, 659 (7th Cir. 1990). The court of appeals, however, rejected this "important criticism" on the grounds that the hospital industry had failed to propose "an alternative that recognized the diversity of the industry but preserved the virtues of a rule." *Id.* This rejection is based on the erroneous assumption that the hospital industry was under an affirmative duty to provide the Board with a rational and nonarbitrary rule.

The court of appeals stated that the hospital industry "joined the unions in opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." *Id.* This statement mischaracterizes the hospital industry's response to the proposed 100-bed distinction. The court of appeals implies that the hospital industry and the union representatives were in agreement in opposing the 100-bed distinction when, in fact, the hospitals and the unions opposed the distinction for very different reasons. The hospital industry argued and provided substantial evidence that the 100-bed distinction was inadequate recognition of the diversity of acute-care hospitals in that it did not take into account the number of beds actually utilized or the nature of services being provided by the hospital. The unions, on the other hand, argued that there is not an adequate correlation between number of beds and

number of staff to justify distinguishing between hospitals. 53 Fed. Reg. at 33927. The Board noted that when the parties suggested alternative bed-number distinctions some unions suggested small hospitals be defined as those with fewer than fifty licensed beds, the AHA suggested a 400-bed distinction, and other employers suggested from 250-beds to 500-beds as the line between small and large hospitals. 53 Fed. Reg. at 33927. To characterize these diverse viewpoints as agreement is misleading and not supported by the evidence before the Board or the court of appeals.

The Board correctly attempted to construct an analytical framework, based upon size, to distinguish among hospitals. It preliminarily failed to draw the line at the appropriate place and in the appropriate manner. Then, instead of reconciling the diverse suggestions and drawing a conclusion based on the evidence before it, the Board, faced with a difficult decision, simply discarded its own accurate analysis that size differentials do affect appropriateness of bargaining units. The court of appeals compounded the error by failing to understand the difference between the unions' and the industry's opposition to the 100-bed standard. The irrational result ignores the actual differences among hospitals and sanctions an arbitrary and capricious rule not based on substantial evidence.

2. The Board's Rationale For Excluding Nursing Homes Applies With Equal or Greater Force To Acute-Care Hospitals.

As described above, NPR I designated appropriate bargaining units for nursing homes. In the Second Notice

of Proposed Rulemaking, however, the Board concluded that there are "significant differences between the various types of nursing homes which affect staffing patterns and duties" and decided to exclude nursing homes from the rule. NPR II, 53 Fed. Reg. at 33928. As evidence in support of this conclusion the Board noted that "[t]o a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered." *Id.* at 33927. This assertion simply is incorrect.

In support of its assertion the Board cited evidence that nursing home facilities range in size from ten to 500 patients. *Id.* As stated above, acute-care hospitals in Missouri vary to an even greater degree, from eighteen to 1,208 licensed beds. The Board also cited evidence concerning the differing levels of care among the three basic types of nursing home facilities: skilled nursing, intermediate care and residential care. *Id.* There are hospitals in Missouri, however, where the level of care varies to an even greater degree within one institution. As stated above, fifty-one of Missouri's 139 acute-care hospitals have nursing home type units. One hospital in Kansas City provides care ranging from acute intensive and emergency care to long term residential care, with several levels and types of care between the extremes.

If the Board's findings with respect to the nursing home industry are correct, its irrebuttable rule for the substantially more diverse and more rapidly changing hospital industry must be incorrect. The Board's rationale for excluding nursing homes from the coverage of the rule requires precisely the same finding when applied to acute-care hospitals. The result of the Board's rationale is

a rule that is arbitrary, capricious, and not based on substantial evidence.

3. The Board's Rationale For Excluding Psychiatric and Rehabilitation Hospitals Applies With Equal Force to Acute-Care Hospitals With Psychiatric and Rehabilitation Units.

The Board's reasoning concerning the applicability of the rule to facilities providing care to psychiatric and rehabilitation patients also is arbitrary and inconsistent. The rule does not apply to facilities that are primarily psychiatric or rehabilitation hospitals, but *does* apply to psychiatric or rehabilitation units within facilities that fit within the rule's definition of an acute-care hospital. Under this scheme, the employees working on one of the floors of a 100-bed psychiatric unit at a large metropolitan hospital would be subject to the rule's mandatory bargaining unit determinations but the employees working at a 100 bed psychiatric hospital would not.⁶ There is absolutely no rational basis on which to make such a distinction.

The reasons offered by the Board in support of its decision to exclude psychiatric hospitals from the rule apply with equal force to psychiatric units within acute-care hospitals. Among the reasons offered by the Board were "that unlike other acute care hospitals, psychiatric hospitals do not provide care for the physically ill," that

⁶ Both situations are found among MHA's members. In addition, forty-five acute-care hospital members have beds licensed for psychiatric services. Twenty-nine acute-care hospital members have beds licensed for rehabilitation services.

"many professionals participate hands-on with patients," that "RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators" and "that there are more paraprofessionals (mental health workers)." NPR II, 53 Fed. Reg. at 33930. These factors exist regardless of whether the psychiatric facility is independent or affiliated with an acute-care hospital.

Missouri truly is a microcosm of the health care industry. The members of the MHA do not fit some artificial hospital profile which fills the Board's need to categorize hospitals and their employees in neat pigeonholes and thereby avoid its statutory obligation to make individual findings in each case. They are real hospitals serving real people in the rural areas, small towns, suburbs and urban centers of an incredibly diverse state. They, their employees and their organizational structures reflect that diversity and it is arbitrary and capricious for the Board to ignore reality in favor of some artificial norm which exists only in the mind of the Board.

II. THE RULE VIOLATES THE CONGRESSIONAL ADMONITION AGAINST THE PROLIFERATION OF BARGAINING UNITS IN THE HEALTH CARE INDUSTRY.

In 1974, when Congress amended the Labor Act to include not-for-profit hospitals, it included in its Committee reports the following admonition:

Due consideration should be given by the Board to preventing proliferation of bargaining

units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).

By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

S. Rep. No. 93-766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

As the District Court in this case recognized "[t]he stakes are higher when the Board makes bargaining unit determinations in the health care field, fragmentation of the workforce is more likely and of greater concern when patient care is at issue." *American Hospital Ass'n v. N.L.R.B.*, 718 F.Supp. 704, 713 (N.D. Ill. 1989). The District Court concluded that, in promulgating a rule which "designates an absolute number of appropriate units and mandates a particular division of the workforce," the Board was not responsive to the express concerns of Congress. *Id.* at 716. The District Court based its conclusion, in part, on the fact that the rule requires the "automatic fragmentation of the workforce into eight units, without regards to the nature and extent of the health services rendered or the dynamics of a particular health care institution." *Id.* at 714 (emphasis in original). The MHA believes that the District Court's conclusion also is supported by the history of organizational activity that has occurred in Missouri, both in the health care industry and elsewhere.

A. The Number Of Units Mandated By The Rule Far Exceeds The Number Of Units Sought And Approved In Missouri Hospital Elections.

Labor organizations in this state have not hesitated to seek to represent acute-care hospital units broader than those that will be mandated by the rule. For example, in a 1986 election at Spelman Memorial Hospital (Case No. 17-RC-9796), a ninety-two bed hospital, the International Brotherhood of Teamsters sought two units, one of professional employees and one of nonprofessional employees. In an earlier election at the same institution in 1980, Local 96 of the Service Employees International Union (Case No. 17-RC-8917) sought the same two units.

In another Missouri case, the Board conducted an election in two units sought by Local 50 of the Service Employees International Union, one of all ambulance department employees and the other of all other employees at Wright Memorial Hospital, a seventy-eight bed hospital in Trenton, Missouri. In that case the finding of a separate unit of ambulance drivers and emergency medical technicians was a result of a unique organizational structure that made such a unit appropriate. *Wright Memorial Hosp.*, 255 NLRB 1319 (1981).

In its review of the Wright Memorial Hospital election the Board concluded, contrary to what might normally be found at larger or tertiary-care institutions, that all registered nurses in the hospital actually functioned as Section 2(11) supervisors and, therefore, were not employees for purposes of organization under the Labor Act. After taking extensive testimony in that case, the Board itself demonstrated why irrebuttable presumptions

and rules are not appropriate in this industry. The Board found that each unit of the hospital operated with one RN per shift and that the RNs "possess and exercise supervisory authority which requires the use of independent judgment and goes beyond the mere exercising of professional judgment." *Id.* at 1319-1320. If the Board had chosen to assume that registered nurses are registered nurses and hospitals are hospitals, it never would have taken cognizance of the organizational structure of the emergency services and the responsibilities of the registered nurses at Wright Memorial Hospital.

The disparity between the units deemed appropriate by the parties in Spelman Memorial Hospital and the Board in Wright Memorial Hospital and the units that will be deemed appropriate for these same hospitals under the Board's rule is staggering. The difference between three units and eight units constitutes undue proliferation. The rule which mandates eight units for hospitals like Spelman Memorial Hospital and Wright Memorial Hospital violates the Congressional admonition against undue proliferation in the health care industry.

B. The Number Of Units Mandated By The Rule Far Exceeds The Number Of Units Deemed Appropriate By The Board In A Missouri Industry That Is Not Subject To A Congressional Admonition Against Proliferation Of Bargaining Units.

The MHA believes that the organizational activity in other industries within the state also is relevant to the issue of what constitutes "undue proliferation." In that regard, the MHA offers information concerning Allied

Signal Corp. (formerly Bendix Corp.), a large aerospace contractor in Kansas City, Missouri.

In the mid-seventies Bendix was the subject of detailed testimony in a case before the Board. At that time Bendix employed approximately 2,200 hourly workers; in 1989 it employed 7,300. The difference in wages, hours and working conditions from top to bottom in hospitals is not greater than the differences between the top and bottom employees in the 116 different job classifications in the production and maintenance unit at Bendix. A similar analysis applies to the skill levels of hospital and aerospace employees. There are tremendous differences between the lowest level service employees and the highest level professional and technical employees in both industries. Both hospitals and aerospace contractors employ janitors and food service employees at one extreme and incredibly highly skilled technical employees at the other. When faced with these facts with respect to Bendix, the Board refused to permit a separate skilled maintenance unit, very similar to that which, by definition, would be appropriate under the acute-care hospital rule. *The Bendix Corp.*, 227 NLRB 1534 (1977).

Thus, at an aerospace contractor, an organization substantially larger and more diverse than the vast majority of hospitals in Missouri, all the employees in over one hundred job classifications are in a single production and maintenance unit, represented by one union. If this single bargaining unit structure is appropriate in an industry that has *not* been singled out as the object of a Congressional admonition against undue proliferation of bargaining units, any rule mandating eight bargaining units for

acute-care hospitals must be found to create undue proliferation.

When Congress issued its admonition against bargaining unit proliferation in the health care industry it did so after careful thought and with full knowledge of what havoc unit proliferation has caused in the construction industry. It ordered the Board to give special consideration to the effect of such a situation on hospitals. It cannot have intended that the Board give any less consideration to hospitals than it has to the aerospace industry and it cannot have intended that the Board be permitted to do by rule what the courts of appeal have not allowed it to do by adjudication.

CONCLUSION

For the foregoing reasons, and those stated in the brief of petitioner, the MHA respectfully requests that this Court reverse the court of appeals for the Seventh Circuit, find that the bargaining unit rule is invalid, and permanently enjoin the Board from applying the rule to bargaining unit determinations in acute-care hospitals.

Respectfully submitted,

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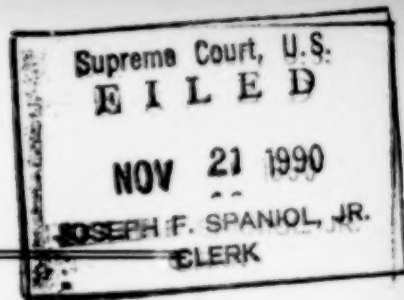
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In The
Supreme Court of the United States
October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,
vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,
Respondents.

On Writ Of Certiorari To The United States
Court Of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF THE GREATER
CINCINNATI HOSPITAL COUNCIL IN
SUPPORT OF THE AMERICAN HOSPITAL
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SUMMARY OF ARGUMENT

1. The National Labor Relations Act Prohibits The Use Of Formal Rules In Bargaining Unit Determinations

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), requires that the National Labor Relations Board make bargaining unit determinations "in each case." The plain meaning of this term requires that the Board consider each case individually. The legislative history of Section 9(b) stresses that bargaining unit determinations depend upon the facts of each particular case. Subsequent legislative actions have not modified the need for individualized bargaining unit determinations. The Board erred in issuing bargaining unit rules in reliance upon this Court's opinions in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969) and *Heckler v. Campbell*, 461 U.S. 458 (1983).

2. Establishing Bargaining Units By Rulemaking Will Make The Health Care Industry Less Effective And Efficient

The adoption of bargaining unit rules by the Board will seriously hamper the ability of hospitals to evolve and adapt in their efforts to provide effective and efficient health care. The "extraordinary circumstances" exception found in the instant rules is a sham which will not allow hospitals the opportunity to have their own particular circumstances considered.

3. The Creation Of Eight Hospital Bargaining Units By Rulemaking Is Arbitrary And Capricious

In *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983), this Court concluded that an agency rule would be found arbitrary and capricious if the agency failed to consider an important aspect of the problem or offered explanations for its decision that were either contrary to evidence or implausible.

The Board's proposed bargaining units for registered nurses and physicians are contrary to the facts determined by the agency and, further, are wholly implausible. The Board concluded that registered nurses should have their own bargaining unit primarily because they were, in the agency's view, "unique." The facts asserted in support of this conclusion are inconsistent, contradictory and implausible. The agency seeks to segregate registered nurses from other professionals, when the agency's own findings reveal that registered nurses work in close coordination with other professionals and are part of an overall complex web of patient care.

The arguments that the Board puts forth for separating physicians can be advanced just as strongly on behalf of every identifiable professional group within a hospital. No basis has been articulated upon which physicians (or registered nurses) should be treated any differently than occupational therapists, laboratory technologists or pharmacists.

With respect to skilled maintenance bargaining units, the Board relies upon factors which utterly fail to distinguish these employees from any other employees. The

Board's real motive in permitting a skilled maintenance unit was to cater to the organizational interests of a particular group of labor organizations.

ARGUMENT

I. INTEREST OF AMICUS CURIAE

The Greater Cincinnati Hospital Council (hereinafter referred to as "GCHC") is an association with its headquarters in Cincinnati, Ohio. The GCHC consists of 34 member institutions, 26 of which are "acute care hospital[s]" as defined in the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 29 C.F.R. 103.30(f)(2), 54 Fed. Reg. 16347-48 (hereinafter referred to as the "Rule"). The GCHC opposes the Rule adopted by the National Labor Relations Board (hereinafter referred to as "the Board"), because it is firmly convinced that the implementation of the Rule would severely and adversely impact the ability of GCHC members to provide health care services to the inhabitants of the Greater Cincinnati area.

II. THE NATIONAL LABOR RELATIONS ACT PROHIBITS THE USE OF FORMAL RULES IN BARGAINING UNIT DETERMINATIONS

A. The Language Of The Statute Mandates Individualized Decision-Making

The language of Section 9(b) of the National Labor Relations Act (hereinafter "the Act"), which has remained unchanged since 1935, states in relevant part:

The Board shall *decide in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the

National Labor Relations Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof

29 U.S.C. § 159(b) (emphasis added).

The term "decide in each case" has a clear and obvious meaning. The ordinary meaning of the word "each" is to consider "individually or one by one" *Random House Dictionary of The English Language* 612 (2nd Ed., Unabridged 1987). The Board is statutorily instructed to decide in each case, "one by one," the appropriate unit in light of the circumstances existing in each individual case. Had Congress omitted the words "in each case," the Board would perhaps be free to "decide" bargaining unit issues in advance by means of rules; however, by directing the Board to examine each case individually before deciding upon appropriate units, Congress foreclosed rulemaking as a means of bargaining unit determination. "[O]f course, no deference is due to agency interpretations at odds with the plain language of the statute itself." *Public Employees Retirement System of Ohio v. Betts*, ___ U.S. ___, 109 S.Ct. 2854, 2863 (1989)

B. The Legislative History Of Section 9(b) Strongly Reflects Congressional Intent That The Board Examine Each Individual Case Before Determining Appropriate Bargaining Units

Labor representatives argued in 1935 that employees themselves should make unit determinations. Hearings on S. 1958 Before Senate Committee on Education and Labor, 74th Cong., 1st Sess. (1935), reprinted in *Legislative*

History of the National Labor Relations Act 1935, at 1679 (hereinafter "1935 Leg. Hist."). Firmly rejecting that approach, Senator Wagner stated:

Now, somebody must decide. Supposing there is a dispute . . . [and] then we have an election to decide who represents the workers. How is the election to be held? Somebody must decide whether the workers in all three plants vote as one, or whether each plant votes separately, or whether there are different crafts which do not relate to one another, where the workers in one craft do not know the problems of the workers in the other craft Somebody must decide it, and that is given as a governmental function to decide.

Id., 1935 Leg. Hist., at 1819-20.

The Senate Report to S. 1958 explained that the Board was empowered, under Section 9(b), to determine appropriate units, because

[o]bviously, there can be no choice of representatives and no bargaining unless units for such purposes are first determined. And employees themselves cannot choose these units, because the units must be determined before it can be known what employees are eligible to participate in a choice of any kind.

S. REP. No. 573, 74th Cong., 1st Sess. (1935), 1935 Leg. Hist., at 2313.

The originally proposed language of Section 9(b) simply stated: "The Board shall decide whether" Proposed Amendments to S. J. Res. 143 (1934), 1935 Leg. Hist., at 1173. The words "in each case" were inserted after "decide" in the final version. As Senator Walsh stated, "[t]he appropriate unit depends so much upon the facts of the particular case that necessarily the Board must

determine the unit " Debates on S. 1958 in Senate, 74th Cong., 1st Sess. (1935), 1935 *Leg. Hist.*, at 2391 (emphasis added). The House Report on the parallel bill also noted that the matter of unit determination "is obviously one for determination *in each individual case* " H. R. Report No. 969 (House Committee on Labor Report to Accompany H.R. 7978), 1935 *Leg. Hist.*, at 2930 (emphasis added). The same explanation is found in House Report No. 972 on S. 1958 (1935 *Leg. Hist.*, at 2976) and in House Report No. 1147 on S. 1958 (1935 *Leg. Hist.*, at 3072). Thus, both the plain language of Section 9(b) and the legislative history of the 1935 Act set forth the clear intent of Congress that, because of the unique facts presented by each different employment setting, the Board must determine the appropriate bargaining unit *in each case*.

In the decision below, the court of appeals erroneously reasoned that the term "in each case" was added to Section 9(b) for only one reason:

[T]o prevent the Board from bringing about a revolution in unit determinations by prescribing employer units, or craft units, or plant units for all employers under the Board's jurisdiction.

American Hospital Association v. NLRB, 899 F.2d 651, 656 (7th Cir. 1990). The appellate court went on to note that the two major labor federations, the AFL and the CIO, had been battling over precisely that issue. The court concluded that the "in each case" proviso had been added in order to forbid the Board from altering "the balance of power" between the labor federations. *Id.*

The appellate court's analysis badly missed the mark. If the proviso was added solely to prevent the Board from

directing that a particular form of bargaining units be prescribed for a particular category of employer, that prohibition would serve just as well to bar the Board from issuing the instant Rule. In essence, the Board has issued a rule prescribing certain types of "craft" units for hospitals, e.g., registered nurses, physicians, and skilled maintenance workers. Thus, if the phrase "in each case" was meant to bar the Board in 1935 from mandating, for example, that only craft units would be permitted in a particular manufacturing industry, that prohibition would have equal force in the present situation. The Rule that the Board seeks to implement is fundamentally contrary to that asserted legislative purpose. We submit that the phrase was added for a broader purpose - that is, to ensure that bargaining unit determinations take into account all of the factual differences that exist between one employment setting and another.

The legislative history of Section 9(b), therefore, is quite clear. The Board must decide each individual case on its own merits, after examining the particular facts of each situation. The language of Section 9(b) is equally clear: "[T]he Board shall decide in each case" This language is mandatory, not permissive; therefore, the Board may not evade its statutory duty by predetermining appropriate units.

C. Subsequent Legislative Actions Have Not Altered The Requirement Of Individualized Unit Determinations

A proviso to Section 9(b) was added by the Labor Management Relations Act in 1947, but the original language of Section 9(b) remained unchanged. The

accompanying Senate Report noted that the "bill still leaves to the Board discretion to review all the facts in determining the appropriate unit." SEN. REP. No. 105, 80th Cong., 1st Sess. 12 (1947). As is apparent, all the facts relevant to any given place of employment can only be discovered through adjudication.

The National Labor Relations Act was amended in 1974 to cover non-profit health care institutions. Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395. Although Congress expressed concern about the potential for proliferation of health care units in its now hotly debated "admonition," Section 9(b) itself was not changed. Congress did not disturb its nearly thirty-year old conclusion that a case-by-case method be used to determine bargaining units.¹ As Board member Johansen noted:

Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action.

NLRB, *Collective-Bargaining Units in the Health Care Industry*; *Second Notice of Proposed Rulemaking*, 53 Fed. Reg.

¹ In 1973, Senator Robert Taft, Jr. introduced a bill which would have created a health care exception to Section 9(b) and mandated four health care bargaining units (plus the statutory guard unit). S. 2292, 93d Cong., 1st Sess. (1935). The bargaining unit approach proposed in this bill was later abandoned by Senator Taft, who thereafter supported the bill which became law on July 26, 1974. The information gleaned from public hearings and Congressional debates convinced Senator Taft and a majority of his Congressional colleagues that the flexible approach mandated by Section 9(b) was as applicable to health care institutions as it has been to all other covered employers.

33900, 33935 (1988) (Johansen, M., dissenting) (hereinafter referred to as "NPRII").

D. The Board's Reliance Upon Its History Of "Rulemaking" Is Misplaced

In NPRII, the two-member majority contended that formal rulemaking was surely permissible because it "has long been the Board's practice to formulate 'rules' to guide it." NPRII, 53 Fed. Reg. at 33901. This assertion is a half-truth. The precedent cited by the Board majority ("Excelsior" rule; "Peerless Plywood" rule)² simply does not support the majority's proposed course of action, because the aforementioned "rules" evolved through the process of case-by-case adjudication. Rather than being "rules" in the sense of the Administrative Procedure Act (hereinafter referred to as "APA") (5 U.S.C. § 553(c)), these cited "rules" merely represent the evolution of guiding precedent.³ In contrast, the present Rule would freeze the evolutionary process.

The majority also contended that rulemaking is authorized under Section 9(b) by citing the various opinions in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969).⁴

² NPRII, 53 Fed. Reg. at 33901.

³ As with all evolutionary processes, adjudicatory "rules" are subject to constant analysis and frequent change. For example, the craft severance "rule" has been re-examined and modified repeatedly. Compare *American Can Co.*, 13 NLRB 1252 (1939) with *National Tube Co.*, 76 NLRB 1199 (1948) with *Mal-linckrodt Chemical Works*, 162 NLRB 387 (1966).

⁴ NLRB, *Collective Bargaining Units In The Health Care Industry*; *Final Rule*, 54 Fed. Reg. 16336, 16338 (1989) (hereinafter referred to as "Final Rule Comments").

In *Wyman-Gordon*, however, the Supreme Court was not addressing bargaining unit formulation. The Board has the undoubted authority to make APA-style rules in many areas; however, the language of Section 9(b) does not permit the Board prospectively to establish or prohibit specific unit determinations. The Board should and must continue to determine appropriate units on a case-by-case basis.

Finally, the Board in its Final Rule Comments⁵ and the appellate court itself⁶ rely upon this Court's opinion in *Heckler v. Campbell*, 461 U.S. 458 (1983), to support their conclusion that the Board may use rulemaking to foreclose individualized unit determinations. *Heckler*, however, is distinguishable because of at least two significant points. First, the provisions of the Social Security Act at issue in *Heckler* explicitly directs the agency to adopt rules to "provide for the nature and extent of proofs and evidence" in hearings. 42 U.S.C. § 405(a). In sharp contrast, the National Labor Relations Act contains the restrictive language of Section 9(b). Second, the rules reviewed in *Heckler* simply establish the national availability of certain types of jobs and therefore do not restrict a claimant's right to establish that he or she has a certain type or degree of disability. Again, in contrast, the Board's Rule virtually converts an employer into a passive participant at a hearing, preordaining the result.

⁵ 54 Fed. Reg. at 16338.

⁶ 899 F.2d at 655-56.

III. ESTABLISHING BARGAINING UNITS BY RULEMAKING WILL MAKE THE HEALTH CARE INDUSTRY LESS EFFECTIVE AND EFFICIENT

Bargaining unit determination by means of formal rules is a hazardous and risky notion, which well may endanger all who must rely upon this country's health care system for survival. The health care industry is in an unprecedented state of ferment. With the explosion of health care costs in the past decade, it is obvious that hospitals need the maximum latitude possible to develop and to experiment with organizational structures in an effort to deliver effective and efficient health care. It therefore seems equally obvious that the health care industry ought not to be fettered by administrative shackles. Health care is not something we can simply do without if it becomes too expensive. Despite this glaring need, the Board is seeking to adopt a course of action that will permit rigid groups of rule-defined employees to compel bargaining, without respect to the needs of a given hospital, its patients or its community. Bargaining unit rulemaking will virtually destroy the ability of hospitals to evolve and adapt.

Although an "extraordinary circumstances" exception is embodied in the Rule, the Board has made quite clear the fact that the use of the exception "will be rare" and that a "heavy burden" will be upon the party seeking to use the exception. NPRII, 53 Fed. Reg. at 33933. In fact, the Board stated in NPRII that "there will be no units found appropriate besides those permitted in the final

rules." 53 Fed. Reg. at 33905.⁷ Thus, preordained rule-made units will be the only units permitted and a hospital will be required to bargain within the parameters of those units no matter what type of organizational structure it might seek to evolve. The advent of such rules will freeze hospital organizations and compel hospitals to organize their workforces in a manner that conforms to the preordained units.

IV. THE RULE CREATING EIGHT HOSPITAL BARGAINING UNITS IS ARBITRARY AND CAPRICIOUS

A. Introduction

After a review of the statutory language, the guiding legislative history and the intent of the 1974 health care amendments, it is our firm conclusion that rulemaking may not be used in the determination of health care bargaining units. While we are in full accord with the argument and conclusions of the American Hospital Association in this regard, we also believe it is appropriate (and hope it will be helpful to the Court) to comment critically with respect to three of the units that the Board has established in the Rule. Those three units are the registered nurse ("RN") unit, the physician unit, and the skilled maintenance unit.

The standard of review applicable to administratively promulgated rules was described by this Court in *Motor Vehicle Manufacturers Association v. State Farm Mutual*

⁷ Reaffirmed in Final Rule Comments, 54 Fed. Reg. at 16345.

Automobile Insurance Co., 463 U.S. 29 (1983), where the Court declared:

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 43. We submit that the arguments and logic underlying these three proposed units are so implausible that the Rule cannot stand.

B. The RN Unit Is Inappropriate

In NPRII⁸ and its Final Rule Comments,⁹ the Board set forth several conclusions that, it contends, support the RN bargaining unit. The Board concluded that "nurses are unique" in several respects. The aspect of this so-called "unique" profession most heavily emphasized by the Board is that the RN profession demands continuous interaction with patients.¹⁰ With whom, one might ask, does the Board think that physical therapists, recreational therapists, speech therapists and occupational therapists continuously work? As is all too apparent, they work with patients, each providing their specialized type of care to patients just as nurses provide nursing care. The

⁸ 53 Fed. Reg. at 33911.

⁹ 54 Fed. Reg. at 16340.

¹⁰ Final Rule Comments, 54 Fed. Reg. at 16341.

duties of these categories of professional employees demand every bit as much "continuous" interaction with patients as do nurses' duties.

The Board also contends that nurses are unique and require a separate bargaining unit because they are primarily supervised by nurses. NPRII, 53 Fed. Reg. at 33911. Once again, the facts do not support the conclusion. Pharmacists are supervised by pharmacists. Laboratory technologists are under the supervision of a director of medical laboratories. On the nonprofessional side, just as nurses are supervised by nurses, food service workers and housekeepers are supervised respectively by food service managers and housekeeping managers. The fact that a director of nursing supervises nurses is neither unusual nor even significant, in that directors of nursing also supervise nonprofessional employees such as nurse aides and ward clerks, technical employees such as licensed professional nurses, and clerical employees such as ward clerks. Contrary to the Board's implication, nurses are not segregated by the organizational systems within hospitals. They are part of an overall complex web of patient care. Ironically, the Rule promotes the organizational segregation of nurses.

The Board stressed its conclusion that the interaction between nurses and other professional groups is neither constant nor regular. NPRII, 53 Fed. Reg. at 33912; Final Rule Comments, 54 Fed. Reg. at 16341. Although this point is refuted by the record,¹¹ even if true it

¹¹ See, for example, Comment S-1375, filed by The Greater Cincinnati Hospital Council with the Board (October 14, 1988),
(Continued on following page)

would not support the Board's effort to segregate RN's. Other professional groups do not work constantly and regularly with each other. Pharmacists, laboratory technologists and physical therapists will only occasionally interact at a professional level. Nevertheless, the Board deemed it prudent to combine these disparate groups into a single bargaining unit. Now, ironically, the alleged fact that RN's may not interact regularly with other professionals is utilized as justification not to include the RN's in a common bargaining unit. Thus, the Board takes a single principle – the lack of interaction – and uses it to group RN's together and then, without blinking, spins about and deems the same principle irrelevant to its decision to group other non-interacting professional classifications into a single bargaining unit.

The underlying and fundamental flaw with the Board's approach of segregating RN's from other professionals is its assumption that RN's are in fact unique. RN's are important, but not unique in any fashion. RN's, like all other hospital professionals, possess specialized training that prepares them for their particular role in the team delivery of health care to patients. RN's, like many types of professionals, work directly with patients; however, other professionals, such as laboratory technologists and pharmacists, tend to work with materials and

(Continued from previous page)

which recites examples of integrated professional teams. "Examples of integration of professional responsibilities within hospitals are numerous, as they have come to represent the norm." *Id.*, at p. 3 (emphasis added).

substances that are as directly related to patient care as is the hands-on care that nurses and professional therapists provide.

The interaction of RN's with other professionals in patient care might be analogized to a wheel. Nurses coordinate and administer treatments usually prescribed by or prepared by other professionals. RN's are the hub of the professional administration of medical care. The Board now seeks to dismember the wheel. In substance, the Board would pull the spokes of the wheel out and throw them into one bargaining unit, while placing the hub in a different unit. The end result of this approach, not to overstrain the analogy, will be to cause the wagon to break down. The professionals work together as a coordinated unit, often using RN's as the mechanism for coordination. To dismember this team would be unconscionable.

C. The Physician Unit Is Not Warranted

The rationale underlying the creation of a separate unit of physicians is even thinner than the rationale for the RN unit. The same fallacious factors relied upon for RN's are trotted out on behalf of a separate physician unit: physicians are supervised by physicians; physicians have a different role in the health care system than other professionals; physicians have unique interests. Every professional group has concerns unique to itself. Need it even be said that any group of employees that has specialized training, a common educational degree, and particular and identifiable duties will have special concerns that arise from those unique characteristics? But if that is the controlling issue, then the Board's logic compels it

to extend separate units to each identifiable professional group: e.g., a unit for pharmacists; a unit for occupational therapists; a unit for laboratory technologists. None of the union representatives that testified proposed such a ludicrous course of action.

An honest assessment of the Board's reasoning here is that the Board has simply plucked certain facts from the records, sometimes accurately and sometimes not, and used the facts to justify separate units for RN's and physicians, and then ignored the existence of those same facts with respect to the other professions that the Board consolidated in a single unit. One obvious example is the Board's statement that physicians would be outnumbered by nurses at a ratio of 15 to 1. One must ask, so what? Many other professionals exist in small numbers within a hospital, but nevertheless will be included in a consolidated unit. Yet, the Board does not rely on the small number of pharmacists relative to RN's to establish a separate unit for pharmacists. This factor is completely irrelevant and the conclusion that the Board reached is specious. No valid reason was suggested by the Board in its NPRII or its Final Rule Comments for separating RN's, and even less reason exists for separating physicians. A single consolidated professional unit will best serve the interests of patients, who are the most important element of this process, and will meet the statutory requirements of the Act.

D. The Asserted Reasons For Establishment Of A Separate Skilled Maintenance Unit Are Implausible

In the fourteen years of litigation involving the health care industry, the Board has taken a multitude of

approaches to determine the appropriateness of one or another particular type of petitioned bargaining unit. Although neither time nor space permits an encyclopedic description of each of those approaches, it is safe to say that the Board has *never* held that a skilled maintenance unit is automatically appropriate in the health care setting.¹² In its initial *Notice of Proposed Rulemaking*, 52 Fed. Reg. at 25142, the Board conceded that the approval of a separate skilled maintenance unit would be difficult to defend in contrast to its refusal to permit the establishment of "other small units of specialized employees." The Board further noted that the establishment of such units, which would be small in absolute and relative terms to other units within a hospital, would be contrary to the admonition to avoid undue proliferation of bargaining units. *Id.* Now, in a stunning about-face, apparently succumbing to the pressure of the AFL-CIO, the Board's Rule establishes a skilled maintenance unit.

In support of this position, the Board cited several factors which, upon analysis, simply do not support its conclusion. For example, the Board stated that "skilled maintenance employees frequently have their own supervision." NPRII, 53 Fed. Reg. at 33921. One might note without contradiction that numerous classifications of employees within a hospital have their own supervision. Food service employees, housekeeping employees,

¹² Compare *Shriners Hospitals*, 217 NLRB 806, 808 (1975) with *The Jewish Hospital Association*, 223 NLRB 614, 616 (1976) with *St. Francis Hospital [II]*, 271 NLRB 948, 954 (1984) (In the context of a proposed maintenance unit, the Board warned that "no unit is *per se* appropriate.")

central service employees, admitting employees, laboratory employees, and virtually every other group within a hospital that can be identified as a group has its own supervision. This factor is absolutely lacking in any substantive content. Similarly, finding that skilled maintenance employees have contact with virtually every other employee in the hospital, the Board concluded that a separate unit is justified because these contacts are relatively brief and limited. *Id.* Many service employees travel throughout a facility and have frequent, brief contacts with other service employees (e.g., housekeeping, food service employees, EKG technicians). The Board does not propose to permit, for example, an EKG unit. How can the fact that a skilled maintenance employee has brief and limited contacts with many other employees serve as a justification for separating that skilled maintenance employee into a different unit? The all too obvious answer is that it presents no justification whatever.

In a transparent effort to minimize the unit proliferation problem, the Board points out that no other labor organizations have sought small units. NPRII, 53 Fed. Reg. at 33922. This simple statement reveals the real motive behind the Board's proposal concerning the separate maintenance unit. The Board's real motive is parallel to the motive behind the proposed establishment of a separate RN unit. Where a labor organization has sought out a particular group of hospital employees for representation in this rulemaking procedure, the Board has succumbed to that request. Just as the American Nurse Association ("ANA") successfully persuaded the Board to carve out RN's in order to serve the interests of the ANA, the skilled trades unions have successfully persuaded the

Board to carve out a maintenance group that they wish to represent. Perhaps the health care industry should be thankful that the Hotel & Motel Workers Union did not seek a housekeeping unit; that the United Food and Commercial Workers did not seek a food service unit; that the Teamsters Union did not seek to represent the patient transport workers; or that the International Union of Electricians did not seek to represent the electrocardiogram operators within a hospital.

The grim humor of this analysis should not obscure the fact that the establishment of a separate maintenance unit, like the establishment of a separate RN unit, is not based upon the testimony or evidence acquired in this rulemaking procedure, but is based upon the extent of organizational interests of particular unions and nothing more than that.

V. CONCLUSION

In sum, we cannot emphasize too strongly the gravity of the error which would be established by the implementation of bargaining unit rules. No other covered industry is as important to this country as the health care industry. Yet, in no other industry has the Board considered the pre-definition of bargaining units without regard to the facts and circumstances of particular employment settings. Not only is rulemaking wrong as a matter of law, it is wrong as a matter of judgment with regard to the health care industry. We ask the Court to direct the Board to abandon this course and to return to

the disparity of interest test and the two regular bargaining units which ordinarily would flow from the application of such a test. The GCHC therefore urges the Court to reverse the decision of the Court of Appeals for the Seventh Circuit and direct that the case be remanded to the United States District Court for the Northern District of Illinois with instructions to reinstate the permanent injunction originally issued by that trial court on July 25, 1989.

Respectfully submitted,

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October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, et al.,

Respondents.

On Writ Of Certiorari To The
United States Court Of Appeals
For The Seventh Circuit

BRIEF OF HOSPITAL ASSOCIATION OF
PENNSYLVANIA, ST. MARGARET MEMORIAL
HOSPITAL AND McKEESPORT HOSPITAL AS
AMICI CURIAE IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST

Hospital Association of Pennsylvania ("HAP"), St. Margaret Memorial Hospital ("St. Margaret") and McKeesport Hospital ("McKeesport") submit this joint brief as *amici curiae* in support of Petitioner, American Hospital Association ("AHA"). Both McKeesport and St. Margaret are "acute care hospitals" as defined in Respondent National Labor Relations Board's (the "Board" or "NLRB") Final Rule for Collective-Bargaining Units in the Health Care Industry (the "Final Rule"), 54 Fed. Reg. 16347-16348 (1989); 29 C.F.R. § 103.30. HAP is a state-wide association of health care institutions.

HAP views itself as the Pennsylvania health care industry's principal forum for developing public policy initiatives and for the exchange of ideas on the effective delivery of quality health care services. To that end, HAP represents its members on a wide variety of matters including legislation and litigation affecting the member hospitals. HAP's entire membership, both unionized and unorganized, is vitally concerned that reasoned legal principles exist for the purpose of making unit determinations in the vast array of differing institutions which make up the hospital community. There is no room for arbitrary, capricious issue resolution in such matters.

McKeesport and St. Margaret, along with all other acute care hospitals and members of HAP, will be directly affected by the Board's Final Rule which was upheld by the United States Court of Appeals for the Seventh Circuit. The AHA has petitioned the Court for review of the Seventh Circuit's decision.

St. Margaret is a 287 bed hospital located in Pittsburgh, Pennsylvania which employs approximately 1,300 regular full and part-time employees. Although none of the employees at St. Margaret are represented by a labor organization, a petition was filed with Region Six of the NLRB on April 27, 1990 by International Union of Operating Engineers, Local 95-95A, AFL-CIO (the "Operating Engineers") by which it seeks to represent a unit limited to 17 skilled maintenance

employees,¹ one of the eight specific bargaining units irrebutably presumed to be "appropriate" by the Board in its Final Rule. 29 C.F.R. § 103.30(a)(5). That petition is being held in abeyance by the NLRB pending the Court's decision in this case.² Thus, St. Margaret and other hospitals similarly situated will be directly affected by the Board's Final Rule, if upheld.³

McKeesport Hospital, located in McKeesport, Pennsylvania, employs 1,584 regular full and part-time employees to care for the needs of patients in its 420 licensed beds. A significant number of the employees at McKeesport are represented for collective bargaining. Both registered nurses and licensed practical nurses are represented in a single unit by the General Staff Nurses Association of McKeesport Hospital, Service Employees International Union, Local 585, AFL-CIO ("Local 585"); skilled maintenance employees are represented by Operating Engineers, Local 95-95A; and the Hospital's service employees are represented by Service Personnel & Employees of the Dairy Industry, Teamsters Local Union No. 205 a/w International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, AFL-CIO (the "Teamsters"). McKeesport's physicians, other professional employees, technical employees, clerical employees, other nonprofessional employees and security guards, are not presently represented by any union.

The recent history of McKeesport is a case study of the disruptive effects of the work stoppages, whipsawing and leapfrogging which Congress feared would result from the

¹ NLRB Case No. 6-RC-10447.

² See N.L.R.B. General Counsel Memorandum, 89-7 (May 30, 1989).

³ The law firm of Cohen & Grigsby represents approximately 35 acute care hospitals in Pennsylvania, West Virginia and Ohio. Significantly, the petition at St. Margaret is only one of four petitions filed by the Operating Engineers now pending at the NLRB's Region Six office in Pittsburgh. The most recent petition, involving St. Clair Memorial Hospital, was filed on September 12, 1990 at NLRB Case 6-RC-10509. The other petitions in Region Six seeking a skilled maintenance unit under the Final Rule involve Shadyside Hospital (NLRB Case 6-RC-10446) and Central Medical Center (NLRB Case 6-RC-10445).

proliferation of health care bargaining units. While the NLRB in its rulemaking has said that it found little evidence that multiple units have resulted in strikes, jurisdictional disputes and whipsawing, McKeesport's experience with only three units contradicts this finding and illustrates the disastrous impact that proliferation will have on the future of labor relations in acute care hospitals if the eight unit Final Rule is upheld.

Because of the serious adverse economic and operational impact that the Board's Final rule has on St. Margaret, McKeesport and other acute care hospitals which are members of HAP, we submit this brief in support of the AHA's Petition.⁴

SUMMARY OF ARGUMENT

The cases of St. Margaret and McKeesport convincingly illustrate the adverse effects that the Board's Final Rule will have on the already troubled health care industry. The concerns which caused the authors of the 1974 Health Care Amendments to the National Labor Relations Act ("NLRA"), Act of July 26, 1974, Pub.L. No. 93-360, 88 Stat. 395, to recognize the need to afford hospitals special protection to minimize the adverse effects of work stoppages and other disruptions to safe patient care remain present and, in some ways have now taken on new proportions. The cost of health care has continued to skyrocket far beyond the expectations of the legislators in 1974 when they commanded the NLRB to take this into account, and threatens to make proper health care unachievable for many Americans. It has never been more important than the present to protect the public interest by affording hospitals the safeguards which Congress envisioned to be necessary when it admonished the NLRB to avoid undue proliferation of bargaining units in hospitals.

⁴ The law firm of Duane, Morris & Hecksher, General Counsel for HAP, concurs with, and joins in the position of amici curiae.

St. Margaret, McKeesport and HAP agree with the AHA that the Final Rule conflicts with the Congressional admonition accompanying the 1974 amendments to "prevent proliferation of bargaining units in the health care industry;" that it is contrary to Section 9(b) of the Act; and that it is arbitrary and capricious and not based on substantial evidence.

The NLRB Final Rule, approved by the Seventh Circuit, is at odds with the legal precedent of the Courts of Appeals in several circuits, including the Second and Third Circuits and creates undue proliferation of bargaining units, particularly insofar as the decision upholds the validity of a separate skilled maintenance employee unit as petitioned for at St. Margaret.

McKeesport's experience colorfully illustrates that the Board's Final Rule is erroneous insofar as it has determined that the work stoppages, whipsawing and leapfrogging feared by Congress when it extended the Act to cover non-profit hospitals, has not occurred in hospitals with multiple bargaining units.

ARGUMENT

A. The Legislative History And The Congressional Admonition Clearly Define The NLRB's Duty To Avoid The Undue Proliferation Of Bargaining Units In The Health Care Industry.

In 1974 Congress amended the National Labor Relations Act to cover all private health care institutions, including non-profit hospitals. Due to the fact that hospitals provide care for the ill, the aged and the infirmed, Congress sought to provide certain restrictions on unit proliferation in the health care industry.

The legislative history of the 1974 Amendments makes clear that Congress considered proliferation of bargaining units a danger to patient care and feared that it would lead to increased costs for medical care. To address these concerns, both the House and Senate Committee Reports contain language agreed upon by both supporters and opponents of the amendments. This legislative history reads as follows:

"Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend towards broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973)." (Footnote omitted)

S.Rep.No. 93-766, 93d Cong., 2d Sess. 5 (1974), reprinted in 1974 U.S.Code Cong. & Ad. News, pp. 3946, 3950, H.R.Rep.No. 93-1051, 93d Cong., 2d Sess. 6-7 (1974).

Senator Taft, one of the primary sponsors of the legislation, explained that the "agreed upon . . . report language . . . [was] endorsed by labor and management groups, including the Service Employees International Union of the AFL-CIO, the Laborers' International Union of North America of the AFL-CIO, many State Hospital Associations . . . the Department of Labor and the Office of Management and Budget" 120 Cong.Rec. 12,944 (1974) (emphasis added).

Senator Taft further explained the rationale for Congress' admonition in the Committee Reports:

"I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of *great caution* being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented

In analyzing the issue of bargaining units, *the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage 'leapfrogging' and 'whipsawing.'* The cost of medical care in this country has already skyrocketed, and the cost must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

The committee in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases." 120 Cong.Rec. 12,944-45 (1974) (emphasis added).

Shortly after the Act was amended, the NLRB considered the appropriateness of bargaining units in a series of cases then pending before the Board.⁵ Having determined that these cases present issues of importance in administration of the Act, the Board held oral argument, and amici curiae briefs were received. From that point forward, the National Labor Relations Board has acknowledged that the Congressional admonition provides special guidance with respect to determining bargaining units in the health care industry. The "*principle thrust of the legislative history of the health care amendments . . . admonishes the Board to avoid undue proliferation of bargaining units.*" *Mercy Hospitals of Sacramento, Inc.*, 217 N.L.R.B. 765, 766 (1975) (emphasis added).

The courts of appeals in heretofore reviewing NLRB cases have uniformly, if not unanimously, recognized a responsibility on the part of the Board by virtue of the admonition to avoid the undue proliferation of bargaining units in the health care industry.⁶ Although the approaches

⁵ *Mercy Hospitals of Sacramento, Inc.*, 217 N.L.R.B. 765 (1975); *Barnert Memorial Hospital Center*, 217 N.L.R.B. 775 (1975); *St. Catherine's Hospital*, 217 N.L.R.B. 787 (1975); *Newington Children's Hospital*, 217 N.L.R.B. 793 (1975); *Sisters of St. Joseph of Peace*, 217 N.L.R.B. 797 (1975); *Duke University*, 217 N.L.R.B. 799 (1975); *Mount Airy Psychiatric Center*, 217 N.L.R.B. 802 (1975); and *Shriners Hospitals*, 217 N.L.R.B. 806 (1975).

⁶ See, *St. Anthony Hosp. Systems, Inc. v. NLRB*, 884 F.2d 518, 521 (10th Cir. 1989) (" . . . when a bargaining unit satisfies the 'disparity of interests' test, it necessarily complies with the Congressional directive against unnecessary fragmentation of bargaining units"); *St. John's General Hospital v. NLRB*, 825 F.2d 740, 747 (3d Cir. 1987) ("The Board must consider the issue of undue proliferation in determining the scope of a bargaining unit"); *Southwest Community Health Services v. NLRB*, 726 F.2d 611, 613 (10th Cir. 1984) ("Congress has admonished the Board to prevent a proliferation of bargaining units in the health care

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recognized by the various courts of appeals vary somewhat it can be gleaned from the decisions that, at the very least, the admonition requires the Board to apply a standard in determining units in the health care industry which is something more than the traditional community of interest standard applied in other industries. When the "smoke and mirrors" are removed from the Board's Final Rule, it is evident that the Board has not substantially departed from its traditional approach and, thus, has not complied with the Congressional mandate to avoid undue proliferation of bargaining units in the health care industry.

In *American Hospital Association v. NLRB*, 899 F.2d 651, 659 (7th Cir. 1990), the decision below, the Seventh Circuit, too, has merely paid "lip service" to Congress' admonition against unit proliferation by concluding that the Board's Final Rule did not constitute undue proliferation in conflict with Congress' intentions.

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industry"); *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1538-39 (11th Cir. 1984), *reh'g den.*, 726 F.2d 755 (11th Cir. 1984) ("A general rule derived from the above cited cases is that the Board must consider Congress's non-proliferation directive and discuss how the Board's action in a particular case comports with that directive"); *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1470 (7th Cir. 1983) (" . . . the circuits including ours have treated [the committee reports] as authoritative"); *Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632-33 (2d Cir. 1983) (" . . . this legislative commitment to nonproliferation, explicit in the legislative history binds the NLRB . . . "); *NLRB v. HMO International/Cal. Medical Group Health Plans, Inc.*, 678 F.2d 806, 808-09 (9th Cir. 1982) ("Because this legislative commitment to non-proliferation is explicit in the legislative history leading to the repeal of the prior exemption, it is binding on the NLRB and must be implemented by it"); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981) (" . . . the Board must expressly consider the congressional admonition in making unit determinations"); *NLRB v. West Suburban Hospital*, 570 F.2d 213, 215-16 (7th Cir. 1978) ("Congress has made it clear that the Board must view evidence of traditional factors in the context of the stated Congressional policy of preventing proliferation of bargaining units in the health care field"). *Contra, International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987).

Legislative history explaining legislative enactments has considerable significance in guiding a court in the interpretation of a statute. While a committee report is not a statute, it can and does illuminate statutory language. This Court has looked to legislative history on numerous occasions to assist it in interpreting Congressional intent in labor legislation, and particularly the NLRA.⁷

Indeed, the decisions of the numerous courts of appeals which have interpreted the statute and the legislative history *require* the NLRB to do more than apply traditional standards to avoid undue proliferation of health care units, and are legal precedent which the NLRB and Seventh Circuit cannot ignore. It is the courts of appeals, not the NLRB, which have been given superior authority by the legislature to interpret the statute. *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191, 194 (4th Cir. 1982) ("a reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation"); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 970 (3d Cir. 1979) (" . . . the Board is not a court nor is it equal to this court in matters of statutory interpretation For the Board to predicate an order on its disagreement with this court's interpretation of a statute is for it to operate outside the law").

The NLRB Final Rule ignores the effect the many courts of appeals have given to the admonition by establishing eight bargaining units to be appropriate based upon nothing more than traditional standards. The NLRB is not free to disregard the superior role of the courts of appeals with regard to the effect to be given legislation, and, by the Final Rule, to depart from now settled law. Therefore, this Court should look to the legislative history of the amendments and protect the public interest by giving effect to the true intent of Congress, to avoid the undue proliferation of bargaining units in the health care industry.

⁷ See, *Edward J. De Bartolo Corp. v. NLRB*, 463 U.S. 147, 154-57 (1983); *National Woodwork Manufacturers Association v. NLRB*, 386 U.S. 612, 640 (1967); *United States v. International Union United Automobile, Aircraft & Agricultural Implement Workers of America*, 352 U.S. 567, 585 (1957).

B. The Board's Final Rule Is Arbitrary And Capricious And Not Supported By Substantial Evidence Insofar As It Ignores The Critical Differences Among Hospitals.

It is truly paradoxical that in the one industry in which Congress' concern for the public interest caused it to specifically instruct the Board to avoid the undue proliferation of bargaining units, it is now the only industry in which the Board has chosen to determine units by blanket rules, which, by their very nature, cause proliferation of bargaining units. Even more curious, perhaps, is that by doing so the NLRB has contradicted its own prior acknowledgments and the numerous and consistent admonishments of the courts of the need for flexibility in determining units in the health care industry.

The diversity of the health care institutions and the need for flexibility in making unit determinations in health care was recognized by the Board from the outset. In *Otis Hospital, Inc.*, 219 N.L.R.B. 164 (1975), a case decided shortly after the amendments became effective, the Board, believing its conclusion to be consistent with the legislative history of the amendments, held that employers and unions should be granted the "broadest possible latitude" in agreeing upon unit compositions, and expressly acknowledged that "*not all health care institutions may be exactly alike.*" It explained:

"That is, we feel, the first lesson learned from the recent debates. *Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise. Practice or standards may differ from one locale to another, not only with respect to collective-bargaining patterns but also with respect to health care delivery itself.* When parties contest the emphasis to be given to such characteristics, we are, of necessity, the arbiter." *Id.* at 165 (emphasis added).

If there has been any change at all since the NLRB's 1975 pronouncements, it is that hospitals have, of necessity, become more diverse due to the increasing complexity of health care and the influences of the market place.

Decisions of the courts of appeals also recognize the diversity of the health care industry and the requirement that the Board consider the particular facts in exercising its discretion in each case when determining health care bargaining units. An early example is *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351 (3d Cir. 1976), where the Board failed to exercise its own discretion in determining an appropriate unit by merely granting comity to a state court certification. In *Memorial Hospital*, the Third Circuit described the Board's responsibility as follows:

"In reviewing the Board decisions under § 9(b), our function is circumscribed by the nature of the Board's responsibility with respect to the determination of appropriate units. *It is clear that '[t]he issue as to what is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision.* It involves of necessity a large measure of informed discretion'" *Id.* at 357 (citation omitted) (emphasis added).

With this precept in mind, the court concluded that the Act and the legislative history of the amendments prohibit the Board from abdicating its duty to decide the appropriate unit in "each and every case." *Id.* at 360. *Accord*, *Long Island College Hospital v. NLRB*, 566 F.2d 833 (2d Cir. 1977).

The courts also heretofore have expressed disfavor of the Board's abdication of its duty to decide appropriate units in health care institutions by reliance on irrebuttable presumptions. In *NLRB v. St. Francis of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979), the Ninth Circuit explained:

"By setting up a policy which is automatically applied and irrebuttable without any examination of the particular situation involved, the Board fails to give 'due consideration' to the congressional directive in that case."

Following this decision of the Ninth Circuit, the Board embraced the court's reasoning in *Newton-Wellesley Hospital*,

250 N.L.R.B. 409 (1980), and expressly disavowed any establishment of irrebuttable presumptions in determining health care units. The Board added:

"Such a *per se* approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide 'in each case' whether the requested unit is appropriate. Moreover, as the court pointed out, the legislative history of the 1974 health care amendments to the Act requires the Board to give due consideration to avoiding an unwarranted fragmentation of bargaining units in this industry. A *per se* rule could result in the Board's giving insufficient attention to this admonition of the Congress, and could permit the splitting of professional or other employees into separate units regardless of whether the particular circumstances warranted such a division." *Id.* at 411 (emphasis added).

While the Board more recently adopted the "disparity of interest" approach in *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) ("St. Francis II"), which essentially presumes the appropriateness of professional and non-professional units, the Board again emphasized:

"We will reach our unit determinations on a case-by-case basis, focusing on the differences shown by the petitioned-for unit from other employees and the similarities among the proposed unit members. *The diverse nature of today's health care industry - including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc. - precludes any generalization as to the appropriateness of any particular bargaining unit.*" *Id.* at 953 n.39 (emphasis added).

Thus, it has been uniformly recognized by the Board and courts, and is clear from the legislative history of the amendments, that the Board has an affirmative duty under Section 9(b) of the Act and the Congressional admonition to consider the critical differences of particular health care institutions before determining appropriate bargaining units and to determine in each case that the units approved do not constitute undue proliferation.

Yet there have been no intervening events or vast changes in the industry to cause the Board to contradict, in the Final Rule, its prior acknowledgments. The health care industry has been, and remains, a very diverse industry in many respects.

HAP represents approximately 252 health care institutions in Pennsylvania which are potentially affected by the rule, of various sizes, in metropolitan, suburban and rural settings. These institutions have significant differences in missions, patient populations, work force structures and reimbursement structures. Virtually all have work forces that are functionally integrated to varying degrees and many utilize concepts such as the team approach to providing health care, multi-disciplinary teams, overlapping work functions, and various forms of departmental organization, staffing and supervision, etc. Nor is the industry static. Several external forces are presently at work influencing the industry to make changes. Among these forces are the rising costs of medical care, shortages of registered nurses and other specialists, changes in levels of reimbursement and, above all, ever changing technology which requires further specialization and diversity in the work force. All will impact different hospitals in different ways and to different degrees. Surely changes in the scope and composition of health care industry work forces are likely to occur, resulting in further diversity, as hospitals explore new and innovative ways to solve these problems.

The Board has consistently relied upon factors such as integration of the work force, employee contact, shared job duties, common supervision and other terms and conditions of employment in evaluating whether groups of employees should be in the same or different bargaining units. While some trends or patterns have developed and are recognized by the NLRB with respect to determining the scope and composition of bargaining units, the NLRB has heretofore refused to apply inflexible rules, in favor of deciding each case based on its own particular facts and circumstances.

Thus, the diverse nature of health care institutions gives rise to significant differences in terms and conditions of employment among hospitals, which the NLRB has consistently acknowledged during its 13 years of deciding cases

under the 1974 amendments. Before rulemaking, it has, as set forth above, consistently expressed its opinion that the admonition precludes it from utilizing any approach which would fail to consider the particular facts of each case. The diversity in health care institutions and their work forces require that unit determinations be made solely on the basis of first hand, institution-specific evidence.

Suddenly, in direct contradiction of its earlier acknowledgments, the NLRB announced that it will determine health care bargaining units by rulemaking. The Board, by its Final Rule, will no longer consider the particular facts in deciding the appropriate unit in each case, abdicating its duty under Section 9(b) of the Act. This drastic change in approach, ostensibly resulting from the NLRB's inability to expeditiously process and determine units on a case-by-case basis or to gain the uniform approval of the courts of appeals does not relieve it of its statutory duty, affirmed by the courts, to avoid the proliferation of health care units merely for the sake of administrative ease. The Congressional admonition to avoid the proliferation of units is of paramount importance to the NLRB's justifications for engaging in rulemaking. A blanket rule which fails to consider these critical differences and the potential for changes in the industry will result in unit determinations in health care which are simply incorrect, even under traditional standards. The Board's failure to consider the critical differences among the various hospitals inescapably leads to the proliferation of units in clear contradiction of the congressional mandate.

C. The Board's Rule Determining That Eight Separate Bargaining Units Are Appropriate Is Inconsistent With The Congressional Admonition To Prevent Undue Proliferation Of Bargaining Units In The Health Care Industry.

The NLRB's Final Rule, determining that eight separate bargaining units are appropriate in all hospitals covered by the rule constitutes undue proliferation of units in violation of

the Congressional admonition. While there may be circumstances where each of the eight units is appropriate, an inflexible rule commanding that all eight units are appropriate in all hospitals covered by the Rule cannot be reconciled with Congress' mandate. The fact that the NLRB and courts have, during years of experience deciding such matters by adjudication, often refused to approve many of the units determined to be appropriate by the Final Rule as being contrary to the admonition, is compelling evidence that the Final Rule causes undue proliferation of health care bargaining units.

Perhaps the best illustration of these points is the manner in which the NLRB and courts have dealt with the skilled maintenance unit since the 1974 amendments. As set forth below, it is evident that in over 13 years of deciding the appropriateness of health care bargaining units, particularly with respect to maintenance employees, the NLRB's determinations have lacked consistency. In fact, before the Final Rule was put into effect, it appears the Board has, more often than not, found separate units of skilled maintenance employees *not* to be appropriate. And, although the Board approved separate maintenance units in many cases, *no* court of appeals has approved such a unit. Thus, the Board's determination by rulemaking that the eight bargaining units are irrebutably presumed to be appropriate in every case, when the Board has not consistently reached such determinations through adjudication or gained the courts' approval of such units, is arbitrary, capricious and not supported by the evidence and results in the undue proliferation of bargaining units contrary to the express intent of the 1974 amendments.

Shortly after the amendments were passed, the Board considered several cases then pending before it concerning the appropriateness of bargaining units. One of these decisions, *Shriners Hospitals*, 217 N.L.R.B. 806 (1975), was the very first case under the amendments in which the Board dealt specifically with the issue of whether a separate unit of stationary engineers is appropriate in the health care industry.⁸ A majority of the Board decided that such a separate unit

⁸ Typically, stationary engineers make up a large portion of skilled maintenance units.

in the health care industry is *not* appropriate in light of the Congressional admonition to avoid undue proliferation of bargaining units:

" . . . Mindful of the congressional mandate and in the exercise of our discretion, we find that, in the health care industry, *the only appropriate unit for collective bargaining which encompasses stationary engineers is a broad unit consisting of all service and maintenance employees of the Employer, excluding professionals and business office clericals.*" *Id.* at 808 (emphasis added).

Significantly, the *Shriners* decision was issued only after a very careful and deliberate analysis of the facts in that particular case, and with the benefit of the records, testimony and arguments presented in the several other cases concurrently considered and decided.

In many similar cases subsequent to *Shriners*, the Board also found separate skilled maintenance units *not* appropriate.⁹ Yet, in other cases separate maintenance units were approved by the Board.¹⁰ But in those cases which were appealed to the courts of appeals, the courts, without exception, refused to accept the NLRB's certification of a separate unit of maintenance employees.

⁹ *Metropolitan Hospital*, 223 N.L.R.B. 282 (1976); *Jewish Hospital Association of Cincinnati*, 223 N.L.R.B. 614 (1976); *Riverside Methodist Hospital*, 223 N.L.R.B. 1084 (1976); *Baptist Memorial Hospital*, 224 N.L.R.B. 199 (1976); *St. Joseph's Hospital*, 224 N.L.R.B. 270 (1976); *The Paul Kimball Hosp., Inc.*, 224 N.L.R.B. 458 (1976); *Greater Bakersfield Memorial Hospital*, 226 N.L.R.B. 971 (1976); *Sutter Community Hospitals of Sacramento, Inc.*, 227 N.L.R.B. 181 (1976); *Anaheim Memorial Hospital Association*, 227 N.L.R.B. 161 (1976); *Northeastern Hospital*, 230 N.L.R.B. 1042 (1977); *Peter Bent Brigham Hospital*, 231 N.L.R.B. 929 (1977).

¹⁰ *McLean Hosp.*, 234 N.L.R.B. 424 (1978); *Hebrew Rehabilitation Center*, 230 N.L.R.B. 255 (1977); *Trinity Memorial Hospital*, 230 N.L.R.B. 855 (1977); *Sinai Hospital of Detroit, Inc.*, 226 N.L.R.B. 425 (1976); *Eskaton American River Healthcare Center*, 225 N.L.R.B. 755 (1976); *West Suburban Hospital*, 224 N.L.R.B. 1349 (1976); *St. Francis Hospital-Medical Center*, 223 N.L.R.B. 1451 (1976).

In *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977), the Third Circuit, certifying the Board's decisions in *Shriners Hospitals* and *Jewish Hospital Association* to be "correct expressions of the law," set aside the Board's order, finding the unit *not* to be appropriate in light of the congressional admonition. The court criticized the Board for mechanically relying on traditional community of interest criteria to find the maintenance unit appropriate, instructing that:

"The legislative history of the health care amendments, however, makes it quite clear that Congress directed the Board to apply a standard in this field which is not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital." *Id.* at 592.

The Seventh Circuit in *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978), also chastised the Board for merely paying "lip service" to the admonition and further criticized the Board for relying on traditional factors in finding a separate maintenance unit appropriate. *Id.* at 215.

Subsequently, the Board, in *Allegheny General Hospital*, expressing disagreement with the courts, again found a separate maintenance unit appropriate.¹¹ The NLRB took exception to the Third Circuit's decision in *St. Vincent's Hospital* in two respects. First, explaining that it had carefully reconsidered the legislative history of the 1974 amendments, the NLRB concluded, that, "with all due respect to the court, Congress did not intend to prohibit such units." *Id.* at 872. Secondly, the NLRB disagreed with the court's holding that the 1974 amendments also precluded the Board from relying on its traditional community of interest criteria in making health care unit determinations. *Id.* at 878.

In *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979), Judge Aldisert, writing the Opinion of the Court,

¹¹ 239 N.L.R.B. 872 (1978).

chastised the Board for ignoring the court's earlier decisions in *Memorial Hospital of Roxborough* and *St. Vincent's Hospital* and, addressing the concept of precedent or *stare decisis*, went on to explain:

"... the Board is not a court nor is it equal to this court in matters of statutory interpretation. Thus, a disagreement by the NLRB with a decision of this court is simply an academic exercise that possesses no authoritative effect. It is in the Court of appeals and not in an administrative agency that Congress has vested the power and authority to enforce orders of the NLRB 29 U.S.C. §160(e). . . . Thus, it is in this court by virtue of its responsibility as the statutory court of review of NLRB orders that Congress has vested a superior power for the interpretation of the congressional mandate. *Id.* at 970 (emphasis added).

Finally, the court held that the Board's use, in the health care industry, of the *American Cyanamid*¹² test, which is merely the traditional community of interest test applied to maintenance units in other industries, is unacceptable since it does not consider the effects of bargaining unit fragmentation or the special public interest in hospital unit determinations.

In *St. Francis II*,¹³ the Board announced that it would henceforth apply the Ninth and Tenth Circuit Courts of Appeals' "disparity of interest" analysis in determining health care bargaining units. When this approach was not approved by the court of appeals, the Board announced that it intended to engage in rulemaking.¹⁴

Thirteen years after the amendments were passed, the Board published its First Notice of Rulemaking 52 Fed.Reg. 25,142 (1987) ("NPR I") which *did not* propose a separate skilled maintenance unit, nor did it propose a separate unit for

¹² *American Cyanamid Company*, 131 N.L.R.B. 909 (1961).

¹³ *St. Francis Hospital*, 271 N.L.R.B. 948 (1984) ("St. Francis II").

¹⁴ The D.C. Circuit refused to enforce the Board Order on the basis that the amendments do not mandate the use of a "disparity of interest" analysis and the court's use of such a test was deemed an erroneous view of the law. *International Brotherhood of Electrical Workers v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987).

business office clerical employees. The Board explained its decision not to find a separate unit of skilled maintenance employees appropriate as follows:

"Similarly, although at times the Board has in the past approved separate units of skilled maintenance employees (including stationary engineers), in our proposed rule we have provisionally included such employees in service and maintenance units for several reasons. First, we have found that their skill levels at times do not greatly exceed those of other unit employees. Second, many skilled maintenance employees work throughout hospitals' facilities, and thus frequently come into contact with other unit employees. Third, inclusion of skilled maintenance employees in broader units will help to prevent unit proliferation. By contrast, if we were to approve separate skilled maintenance units, many of which would be quite small both in absolute size and relative to the remaining service and maintenance employees, we might well be faced with requests to grant other small units of specialized employees; were we to grant such requests, we would open the door to unit fragmentation and proliferation. Finally, as a practical matter, *when the Board has approved separate maintenance units, its decisions have fared poorly in the courts.*" 52 Fed.Reg. at 25,147 (footnotes omitted) (emphasis added).

In NPR II, 53 Fed.Reg. 33,900 (1988), the Board reversed the position it took in NPR I and announced that a skilled maintenance unit would constitute a separate appropriate unit. Curiously, the Board essentially considered the same factors as it had in numerous previous cases and NPR I, but reached an opposite result.¹⁵

¹⁵ In a futile effort to demonstrate that the Board's adjudication of bargaining unit cases has been uniform, the NLRB suggested in NPR II that the varying results for skilled maintenance units were largely a function of a single Board member, Member Jenkins, reaching different results in different cases. NPR II, 53

(Continued on following page)

The courts of appeals reviewing hospital unit cases have virtually all expressed that the Congressional admonition *requires* the Board to use a standard which is more than the traditional standards used in other industries to determine units. But the Board, choosing to ignore the courts of appeals, as illustrated by the manner in which maintenance units were determined, continued to apply traditional community of interest criteria, thereby failing to properly consider Congress' mandate to avoid undue proliferation.

Although the Board attributes its changes in position in its Final Rule to careful consideration of evidence amassed during rulemaking, it is clear from a review of the many cases in which the NLRB considered the maintenance employee issue, that the wages, hours and other terms and conditions of these employees, relative to other hospital employees, have not significantly changed during the 16 years since the amendments.

The record shows that the NLRB decided more than 30 cases dealing with separate maintenance units on a case-by-case basis prior to NPR I. Surely, in its typical, thorough Board fashion, it developed complete, first-hand records in these cases, including testimony of employees, supervisors and managers of those hospitals, all of whom testified under

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Fed.Reg. at 33,903. What the Board fails to mention in NPR II is that in each of those cases where skilled maintenance units were found *not* appropriate, at least two other Board members, most often Members Penello and Walthers, rejected the skilled maintenance unit. While it may be true that Chairmen Murphy and Fanning were remarkably uniform, it is at least equally significant that other Board members, including Chairman Van DeWater and Dotson and Members Dennis, Johanson and Babson, in different opinions, expressed the view that separate maintenance units are not appropriate. *The Community Hospital at Glen Cove*, 278 N.L.R.B. 80 (1986); *St Francis Hospital*, 265 N.L.R.B. 1025 (1982). Finally, it is also significant that Chairman Murphy and Member Fanning, in finding separate maintenance units appropriate, relied on the *American Cyanamid* test, which is nothing more than a mere application of community of interest criteria, and which, we submit, does not adequately consider the admonition to avoid the undue proliferation of bargaining units and has since been rejected by the courts. See *Greater Bakersfield Memorial Hospital*, 226 N.L.R.B. 971 (1976).

oath and were subject to cross examination, and obtained necessary documentation, records and exhibits, etc., before rendering its decisions. After reviewing its experience during 13 years of carefully deciding these issues through adjudication, based upon extensive institution-specific records, the Board determined that a separate maintenance unit is *not* appropriate. The Board's analysis and conclusion in NPR I were correct insofar as the Board concluded therein that a separate unit of skilled maintenance employees is *not* appropriate. The Board's Final Rule as to skilled maintenance units is based only on a record of generalities and upon the self-serving testimony of special interest groups without regard to the actual experiences of the many, very different institutions and patient care communities which will be affected.

The Board's Final Rule finding separate units of skilled maintenance employees appropriate also ignores uniform precedent in the courts of appeals which holds that such units constitute undue proliferation in contradiction of the Congressional admonition. Since 1974, as we noted above, three courts of appeals in seven separate cases denied enforcement of Board Orders finding separate maintenance units appropriate, while *no court of appeals has ever approved such a unit*.

The NLRB has overstepped its authority by implementing a rule which ignores clear legal precedent. The courts of appeals are the statutory courts of review of NLRB orders, and as such, are vested with a superior power to interpret the congressional mandate.¹⁶ "Congress has not given to the NLRB the power or authority to disagree, respectfully or otherwise with decisions of this court." *Allegheny General Hospital v. NLRB*, 608 F.2d at 970.

Finally, the Board's own lack of consistency in deciding the appropriateness of health care bargaining units, such as

¹⁶ *NLRB v. Ashkenazy Property Mgmt. Corp.*, 817 F.2d 74 (9th Cir. 1987); *Hillhouse v. Harris*, 715 F.2d 428 (8th Cir. 1983); *Beverly Enterprises v. NLRB*, 727 F.2d 591 (6th Cir. 1984); *Kitchen Fresh, Inc. v. NLRB*, 716 F.2d 351 (6th Cir. 1983); *J.P. Stevens & Co. v. NLRB*, 638 F.2d 676 (4th Cir. 1980); *Ithaca College v. NLRB*, 623 F.2d 224 (2d Cir. 1980); *Yellow Taxi Co. of Minneapolis v. NLRB*, 721 F.2d 366 (D.C. Cir. 1983).

separate maintenance units, is further cause not to apply a blanket rule to such determinations. A rule which operates to find separate units appropriate without exception when contrary results would often be reached if the same cases were decided on a case-by-case basis is clearly arbitrary and inescapably leads to further proliferation of bargaining units contrary to the Congressional admonition.

D. Proliferation Of Bargaining Units Leads To The Types of Problems Congress Feared When It Passed The 1974 Health Care Amendments.

Congress' concern about proliferation of bargaining units in hospitals was based upon a fear that proliferation would lead to numerous work stoppages, jurisdictional disputes, and wage and benefit whipsawing and leapfrogging, which, in turn, would add to the already skyrocketing costs of medical care. *See supra* pp. 5-6. The Board, in NPR II, examined the "evidence" presented in connection with its rule-making procedure and concluded that there was "little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation." 53 Fed. Reg. at 33908. As the AHA pointed out, however, "the Board's 'finding' ignores the fact that there has *not* been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach."¹⁷ Brief for American Hospital Association, Petition for A Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 22; *American Hospital Association v. NLRB*, No. 90-97 (1990). The Seventh Circuit's sanctioning of the NLRB's clear disagreement with Congress and the court's over the effects of unit proliferation is erroneous.

¹⁷ By the Board's own admission, only about 10% of organized hospitals negotiate three or more contracts. 53 Fed. Reg. at 33908. For the Board to conclude on the basis of that record that eight units are appropriate and that such proliferation will not lead to the problems feared by Congress is, as the AHA notes, "sheer speculation." Brief for American Hospital Association, Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 22; *American Hospital Association v. NLRB*, No. 90-97 (1990).

McKeesport is an example of a hospital that has experienced negotiating and administering contracts with multiple units. Although the three bargaining units at McKeesport are several fewer than the eight permitted by the Final Rule, McKeesport's experience in dealing with as few as 3 units is indicative of the problems hospitals will face when multiple units are certified by the NLRB. McKeesport's labor history graphically illustrates the future of hospital bargaining if the Final Rule is permitted to stand.

Contrary to the NLRB's "finding" in NPR II,¹⁸ McKeesport's experience has been that multiple units have resulted in multiple work stoppages and threats of work stoppages, wage and benefit whipsawing and leapfrogging, multiple contract negotiations, labor arbitrations and other matters which cause significant disruptions to patient care and contribute to escalating health care costs. In short, McKeesport's recent history proves that the concerns expressed by Congress as it passed the 1974 Health Care Amendments remain valid, and in McKeesport's case, have come to fruition.

As mentioned above, McKeesport has three units of represented employees. It has the potential for five, or even six, additional units under the NLRB Final Rule. Contracts for all three of McKeesport's units were due to expire in the first half of 1988. In December 1987, Teamsters Local 205, which already represented the Hospital's service employees, petitioned the NLRB for an election in a unit of technical and clerical employees. An election was scheduled for February 19, 1988. SEIU Local 585 and Office and Professional Employees International Union, Local 457, AFL-CIO, also secured places on the ballot and became involved in the organizing campaign.

During the election campaign, in what is widely-believed to have been a show of strength intended to influence the

¹⁸ The Board does not discuss the effects of proliferation in its Final Rule other than to note that it had thoroughly considered such arguments in NPR I and NPR II and that no further consideration or response was required. 54 Fed. Reg. at 16337.

election and "whipsaw" the Hospital, 250 of the employees represented by the Teamsters walked off their jobs, without giving the Hospital notice as required by Section 8(g) of the Act, 29 U.S.C. § 158(g).¹⁹ In fact, the teamster walkout came without any warning. It was also in derogation of a no-strike clause in the labor agreement. When the employees refused to return to work, McKeesport had no choice but to replace the employees participating in the illegal walkout in order to continue to provide care to its patients.

As could be expected, the illegal walkout and McKeesport's reaction triggered a flurry of legal actions. McKeesport filed unfair labor practice charges against the Union for violation of Sections 8(g) and 8(b)(1)(A) of the Act, 29 U.S.C. §§ 158(g), 158(b)(1)(A), and brought suit in federal court seeking, *inter alia*, damages under Section 301 of the Labor-Management Relations Act, 29 U.S.C. § 185. The Teamsters, for its part, also filed unfair labor practice charges and grieved the Hospital's decisions to terminate and replace its members. After the parties disputed the

¹⁹ In NPR II, the Board suggested that hospitals seek common expiration dates to solve problems caused by recurring near-strikes including multiple § 8(g) strike notices. 53 Fed.Reg. at 33909. Not only is such a suggestion incredibly naive, ignoring as it does the realities of hospital bargaining, but McKeesport's experience has shown that contemporaneous expiration dates actually exacerbate problems rather than solve them. Unions have recognized the bargaining leverage separate expiration dates provide. It is thus highly unlikely that a self-respecting union would simply give away this leverage in order to serve the public interest of forestalling problems caused by recurring near strikes. Even assuming that a hospital could negotiate common expiration dates, that would not assure that all of its unions would give simultaneous § 8(g) strike notices. The timing of such notices is entirely within the discretion of the union. If a union was inclined to work beyond the contract expiration date, it could simply delay giving its § 8(g) notice and unions acting in concert could "whipsaw" the hospital to death through sequential and multiple notices of an impending strike. The hospital would then be forced either to allow the employees to work under the expired contract or to lock them out and cause a disruption of its operations. Following the Board's suggested approach would virtually require a hospital to close down and lay off non-striking employees every time the multiple contracts were set to expire. Planning to operate a hospital under the simultaneous threat of multiple work stoppages would be virtually impossible.

arbitrability of the grievances because of the effect of Section 8(d) of the Act on the employees' status, 29 U.S.C. § 158(d), the Union brought suit in federal court to compel arbitration.

Contemporaneous with the illegal Teamsters strike, negotiations had begun with SEIU Local 585 for the nurses' unit. Local 585 was involved in the NLRB election campaign for the technical/clerical unit and obviously sought to use the negotiations to bolster its chances of victory in the election.²⁰ In this charged environment, the nurses came to the bargaining table disgruntled about perceived wage inequities and fringe benefit disparities in the expiring contract. At the bargaining table, SEIU Local 585 sought to make up for these perceived disparities and demanded substantial increases. As negotiations continued, Local 585 informed the hospital that it would strike on March 22, 1988.

In response to Local 585's Section 8(g) 10-day strike notice, McKeesport had no choice but to take the steps that any prudent hospital *must* take to protect the well being of patients when faced with a Section 8(g) strike notice. Thus, McKeesport began to curtail admissions, canceled elective surgeries and began preparations to transfer patients to other institutions. McKeesport also began to implement plans to lay-off other employees and to consolidate operations by closing several hospital units. Fortunately for McKeesport's patients and the community, the Hospital and Local 585 reached agreement on the eve of contract expiration, thereby averting a strike.²¹

²⁰ The first election in the proposed technical/clerical unit was held on February 19, 1988. No union received a majority vote. The NLRB then scheduled a run-off between the Teamsters and "No Union" on March 17, 1988. At the March 17 run-off election, the employees voted to remain unrepresented.

²¹ Contrary to the NLRB's assumptions, Section 8(g) has been somewhat of a mixed blessing. While it undoubtedly protects hospitals and their patients when a strike does occur, it places a burden upon hospitals and their patient community in the many more cases where the contract is settled short of a strike, almost always at the eleventh hour after the 8(g) notice and the hospital's prudent preparatory response. Most unions tend to give section 8(g) notices 10 days prior to contract expiration as a matter of course. The hospital, its physicians, its

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The agreement with Local 585 provided for significant economic increases. Because of Local 585's leverage, and in the context of the ongoing Teamster troubles, the Hospital was pressured to accede to many Union demands since a nurse's strike most assuredly would have closed the Hospital for the duration of the strike, and quite possibly could have forced permanent reductions in the Hospital's operations due to the concurrent lingering effects of the Teamsters' walkout. Patients would have to be discharged or transferred.

Shortly after narrowly averting a strike by the nurses, McKeesport was again involved in difficult contract negotiations – this time with Teamsters Local 205.²² These negotiations were conducted in the very charged environment following the Teamsters' election defeat and the many legal and other disputes between the Teamsters and the Hospital occasioned by the illegal walkout.

Just two months later, the Hospital faced the expiration of the Operating Engineers' contract who also demanded a hefty increase, leveraging off the effects of the labor disputes with SEIU and the Teamsters. Once again, the Hospital was compelled to maintain labor peace and to recognize the Operating Engineers' leverage. After the illegal Teamsters' walkout and the near strike by the nurses, McKeesport could not risk further negative effects from another work stoppage or the attendant legal costs if it had to face a strike by its maintenance workers, who, while small in number, occupied positions critical to continued operation of the Hospital.

Before McKeesport had fully recovered from the 1988 labor problems occasioned and exacerbated by the multiple units, the Hospital was faced with a new, serious threat. The nurses' contract

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patients and their families incur significant economic, operational, emotional, professional and quality of care burdens in responding to a § 8(g) notice. Those burdens will be exacerbated as the potential for even more frequent notices is created by the existence of additional separate bargaining groups as encouraged by the Rule.

²² The Teamster agreement expired May 1 and the negotiations actually had begun before March 22 while the Nurses' negotiations were still in progress.

with SEIU Local 585, negotiated in 1988, expired in the spring of 1990. Unlike 1988, however, the parties were unable to reach agreement in time to prevent a strike. The work stoppage lasted from March 1 until March 17, 1990. The impact on patient care and other hospital operations was dramatic. The economic consequences were substantial. Once again, the hospital had to implement its strike contingency plans even before the strike began. Admissions were curtailed, non-essential surgery was cancelled, and patients, some seriously ill, were transferred by ambulance to other institutions. The hospital had to "staff-down" because of the strike and in the process laid off hundreds of service, maintenance, technical, and clerical employees. Additional units obviously would pose a very real threat of additional strikes.

The lay-offs and subsequent recall of these employees engendered further labor disputes involving the employees represented by other labor organizations. Numerous employees grieved either their initial lay-off or circumstances relating to their recall. There were over 50 such grievances pursued to arbitration. Other side effects of the lay-offs include severely dampened employee morale and heightened tensions between the various units of Hospital employees. McKeesport expects that these and other problems resulting from the nurses' strike may continue well into the future.

McKeesport's 1988 labor problems from its multiple units and the experience with the 1990 nurses' strike resoundingly affirm the validity of Congress' concerns upon passage of the 1974 Health Care Amendments. With the Teamsters, Operating Engineers and SEIU contracts all expiring within the same general time period, each union used the other unions' threats, demands and bargaining gains as leverage to gain agreement for its own bargaining proposals. Further, we submit, both the Teamsters and Local 585 undoubtedly used the negotiations to attempt to influence to NLRB election in the technical/clerical unit.

Finally, the nurses' strike caused disruptions not only in patient care but in the Hospital's relationship with its other Unions. The end result of these activities by multiple units was precisely the kind of whipsawing, leapfrogging and work stoppages that Congress feared when it passed the Health

Care Amendments. Despite these experiences, which undoubtedly are or will be repeated at other hospitals with multiple units, the NLRB found little "evidence" that Congress' concerns were valid. That conclusion is flawed.

The time, effort and expense associated with negotiating and administering contracts with multiple units has dramatically increased non-patient care related operating costs at McKeesport.²³ Such costs will certainly increase exponentially if the NLRB's eight unit Final Rule is permitted to stand, all at a time when Congress and the public have become increasingly alarmed about rising health care costs. In this regard, a recent study predicts that the per capita cost of health care in this country will increase 127% from 1990 to the year 2000. The same report found that increases in total health care spending exceeded increases in per capita spending between 1980 and 1990 by more than 24%.²⁴ The government, which already bears a substantial burden of health care costs, will be faced with sharing more of the burden, or reducing programs, as evidenced by recent changes in the hospital reimbursement system.²⁵

²³ For example, in its Final Rule, the Board itself cites evidence that negotiation of a single collective bargaining agreement can cost between \$15-40,000 in legal fees alone. 54 Fed.Reg. at 16339. Other costs for negotiations which are also very significant include staff time devoted to actual bargaining, costs associated with surveying local wage rates in other institutions, drafting and costing contract proposals and counter-proposals, studying the potential impact of proposals on operations and clerical duties relating to the preparation of draft proposals, bargaining notes and final proposals. Unless some economies could be achieved, these costs potentially would be multiplied *eight times* if the Board's Final Rule is permitted to stand. Further, the NLRB's Rule is totally unmindful of the fact that the burden of these costs ultimately falls upon the patient-consumers of health care services and, to a large extent, upon the United States government which foots the bill for a significant percentage of all health care expenses.

²⁴ *Families USA Calls for Bold Action to Stem Health Care Cost Explosion*, Daily Lab.Rep. (BNA) No. 212 at A-10, A-11 (Nov. 1, 1990).

²⁵ In 1982, Congress enacted the Prospective Payment System, which revised the Medicare payment system. Under this system, Medicare patients' diagnosis, rather than the cost of treating the patient, dictates the amount of reimbursement received by the hospital. Diagnostic related groups ("DRGs") become an integral part of the system. DRGs establish the amount of payment

Additionally, many hospital costs and increases are non-reimbursable. Government payments to hospitals under Medicare and Medicaid – which together account for about one-half of all hospital revenues and, in the case of McKeesport, account for approximately 68% – are falling far behind the actual costs of delivering care.

These changes have an immediate impact on the magnitude of declining revenues. Today, many hospitals are facing critical financial situations and it has been projected that the number of acute care hospitals in this country will decline drastically as a result of involuntary closings which will deprive communities of much needed health care.

Concurrently, as non-hospital-based health care delivery systems have been developed, admissions have declined leaving hospitals with fewer, but more acutely ill patients and leaving hospitals even more vulnerable to DRG reimbursement. Shortages in a variety of health care professions, such as nursing, have caused a drastic increase in the labor costs associated with those professions.

Even as hospitals search for solutions to these changes, the problems are intensified by new challenges. Hospitals such as McKeesport are not only faced with providing care to an increasingly acutely ill and aging patient population, but also with providing increasingly larger amounts of unreimbursed care to uninsured patients and to patients with AIDS and drug related conditions.

As is apparent from the foregoing, Congress' concern of increased costs resulting from unit fragmentation applies with even more urgency in today's economy. Thus, it is imperative that the NLRB pay heed to Congress' admonition and recognize this important public interest in preventing unit proliferation.

(Continued from previous page)

associated with any particular illness or condition. DRGs are based upon the costs typically involved in treating a specific illness or condition. Unfortunately for the hospital, the amount of DRG reimbursement was usually unaffected by patients whose treatment does not fall within the norm in terms of length of stay, procedures performed, etc. Thus, the amount of reimbursement received by the hospital often does not correlate to the cost incurred by the hospital.

As stated above, at McKeesport, for example, about 68% of all admissions are paid for by Medicare or the Pennsylvania Medical Assistance Program. Other Southwestern Pennsylvania hospitals compare at approximately 67%. *Hospital Costs Rise 17.4%*, Pittsburgh Post-Gazette, Aug. 14, 1990 at 6, col. 2. As a result, public funds budgeted for these critical programs, which would otherwise be used in direct patient care activities, will, by necessity, be used to cover increased operating costs resulting from strikes, multiple union organizing campaigns and negotiations, whipsawing and leapfrogging.²⁶ The public interest is not served by diverting public funds from critical health care programs to cover non-patient care activities, thereby decreasing the quality and amount of health care available to people who rely on such programs.

The NLRB in its rulemaking essentially ignored the public interest in affordable health care as a factor militating against unit proliferation. In its Final Rule, referring to the "implicit policy" of the 1974 amendments, the Board concluded:

The statutory amendments enacted by Congress in 1974 represented an *implicit* policy decision that collective bargaining in the health care industry will produce countervailing benefits justifying the cost.

54 Fed.Reg. at 16,339 (emphasis added). This "implicit" policy should not be given paramount importance over Congress' *expressed* concern to control health care costs by avoiding the proliferation of bargaining units, particularly when it has not been shown by the NLRB that fragmentation

²⁶ Several labor organizations have made it known publicly that they have planned massive organizing efforts at hospitals if the Final Rule is upheld. National Union of Hospital and Health Care Employees President Henry Nicholas recently announced that the NUHCE will triple its monthly union dues to finance a massive organizing effort. *Health Care Employees Union Plans Massive Organizing Campaign*, Daily Lab.Rep. (BNA) No. 213 at A-18 (Nov. 2, 1990). The American Nurses Association and other unions have made similar claims. *ANA Facing Challenges From Rival Nurse Unions*, Daily Lab.Rep. (BNA) No. 120 at A-5 (June 21, 1990). Hospitals will be required to expend commensurate resources to respond to the legal proceedings engendered by these increased efforts.

of units is absolutely necessary to afford employees the benefits of collective bargaining. The Board simply brushed aside Congress' *express* policy decision that unit proliferation should be prevented because of its negative impact on health care costs. By upholding the Board's Final Rule, the Seventh Circuit has sanctioned the Board's clear departure from Congress' intent.

The experience of McKeesport in dealing with only three units, instead of the eight units set forth in the Final Rule, is compelling evidence that the proliferation of units in hospitals not only causes disruptions to patient care by work stoppages, multiple contract negotiations and whipsawing and leapfrogging, but also increases medical costs and threatens the financial stability of hospitals which encounter these tactics effectively utilized by unions.

CONCLUSION

For the foregoing reasons, St. Margaret Memorial Hospital, McKeesport Hospital and Hospital Association of Pennsylvania, *amici curiae*, respectfully request that the Court reverse the Court of Appeals' decision.

Respectfully submitted,

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In The
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AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The
United States Court Of Appeals For The
Seventh Circuit

BRIEF OF ST. FRANCIS HOSPITAL, INC. OF
MEMPHIS, TENNESSEE AS AMICUS CURIAE IN
SUPPORT OF PETITIONER AMERICAN
HOSPITAL ASSOCIATION

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QUESTIONS PRESENTED FOR REVIEW

- I. DOES THE BOARD'S NEW EIGHT-UNITS RULE VIOLATE THE STATUTORY MANDATE CONTAINED IN SECTION 9(b) OF THE NATIONAL LABOR RELATIONS ACT THAT COLLECTIVE-BARGAINING UNITS ARE TO BE DETERMINED FROM THE FACTS IN EACH CASE?
- II. EVEN ASSUMING THAT THE BOARD'S NEW RULE PRESUMING EIGHT-UNITS WOULD BE OTHERWISE APPROPRIATE, DOES THE BOARD'S MAKING SUCH A PRESUMPTION EFFECTIVELY IRREBUTTABLE VIOLATE THE SECTION 9(b) "IN EACH CASE" REQUIREMENT?
- III. IS THE BOARD'S EIGHT-UNITS RULE CONTRARY TO CONGRESS' ADMONITION TO AVOID UNDUE PROLIFERATION OF BARGAINING UNITS IN THE HEALTH-CARE INDUSTRY?

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No. 90-97

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BRIEF OF ST. FRANCIS HOSPITAL, INC. OF
MEMPHIS, TENNESSEE AS AMICUS CURIAE IN
SUPPORT OF PETITIONER AMERICAN
HOSPITAL ASSOCIATION

INTEREST OF THE AMICUS CURIAE¹

St. Francis Hospital, Inc. of Memphis, Tennessee (hereinafter St. Francis) is an acute-care hospital and, therefore, is affected by the Rule promulgated by the

¹ This brief of Amicus Curiae is filed with the written consent of the parties. The letters giving consent have been separately filed with the Court.

National Labor Relations Board regarding appropriate bargaining units in the health-care industry. St. Francis, having been exposed to organizing efforts by groups of its employees and involved in years of related litigation (see *St. Francis "I"*, 265 N.L.R.B. 1025 (1982), and *St. Francis "II"*, 271 N.L.R.B. 948 (1984)), is acutely aware of the need to consider each request for a collective-bargaining unit on the facts of the particular case and the need to avoid undue proliferation of bargaining units in the health-care industry.

St. Francis is keenly interested in the outcome of this matter. If the Board's rule prevails, creating a virtually irrebuttable presumption that eight units are appropriate, St. Francis could be subject to organizing in the same maintenance unit found inappropriate in the past. St. Francis would have to challenge the appropriateness of the unit again, inevitably resulting in further litigation. St. Francis, therefore, submits this Brief in Support of the Petitioner American Hospital Association and requests that this Court find that the Rule promulgated by the National Labor Relations Board is invalid and reverse the judgment of the United States Court of Appeals for the Seventh Circuit.

STATEMENT OF THE CASE

This case arises out of a suit by the American Hospital Association (hereinafter, AHA) to permanently enjoin the National Labor Relations Board (hereinafter, NLRB or the Board) from enforcing its newly promulgated Rule, 29 C.F.R. § 103, pertaining to bargaining units in the health-

care industry (hereinafter, the Rule). Promulgated under Section 6 of the National Labor Relations Act (the NLRA or the Act), 29 U.S.C. § 156, the Rule establishes eight units, and only eight units, as presumptively valid for collective-bargaining purposes in the acute-care hospital industry. In promulgating the Rule, the Board has disallowed parties from raising as reasons to rebut the presumption virtually all of the factors raised by parties for the past 13 years to dispute unit appropriateness.

AHA asked the district court below to declare the Rule invalid, based on three alternative grounds: (1) the Rule contravenes Section 9(b) of the Act, 29 U.S.C. § 159(b), which provides that bargaining-unit determinations must be made "in each case," (2) the Rule contravenes the 1974 health-care amendments, which mandate that the Board avoid undue proliferation of bargaining units in the health-care industry, and (3) the Rule is arbitrary and capricious and is not supported by substantial evidence. *American Hospital Association v. NLRB, et al.*, 718 F. Supp. 704, 705 (N.D. Ill. 1989). The district court found the Rule invalid and granted AHA's request for injunctive relief. *Id.* at 716. The court stated that the "in each case" language required the Board to make unit determinations tailored to each individual case. *Id.* at 712-13. The court found that this limitation did not foreclose the Board from undertaking rulemaking in fulfilling its Section 9(b) charge, but the court left for another day the question of limitations to the Board's rulemaking function under Section 9(b). The court further found that, in light of the congressional admonition to give consideration to undue proliferation of bargaining units in the

health-care industry, a rule that designates such an absolute number of appropriate units and mandates a particular division of the workforce is not responsive to Congress' express concern. *Id.* at 716. The court found it unnecessary to reach AHA's claim that the Rule was arbitrary, capricious, and not supported by the evidence. *Id.*

The NLRB appealed the district court's decision, and, in *American Hospital Association v. NLRB, et al.*, 899 F.2d 651 (7th Cir. 1990), the Seventh Circuit reversed, finding that Section 9(b) does not require the Board to make bargaining-unit determinations on a case-by-case basis, and that, to the extent that unit determinations must be made on a case-by-case basis, the Board's resort to formal rulemaking satisfied this requirement. The Seventh Circuit further found that the Rule did not violate the congressional admonition and that the rule as promulgated by the Board was not arbitrary or capricious. *Id.* at 659-60. Thereafter, AHA petitioned this Court for a Writ of Certiorari, pursuant to 28 U.S.C. Section 1254, such Petition being filed within 90 days of the entry of judgment of the Court of Appeals. Pursuant to Supreme Court Rule 37, St. Francis as *amicus curiae* filed a timely brief in support of Petitioner American Hospital Association. On October 9, 1990, this Court granted the Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit.

SUMMARY OF THE ARGUMENT

Although the Act does not entirely foreclose the Board from promulgating rules regarding the determination of appropriate collective-bargaining units, a rule, such as the present one, which does not give consideration to the congressional mandate that collective bargaining units be determined upon the facts of each individual case, is improper. The Rule is inconsistent with the language of the NLRA that unit determination be undertaken on an individual case-by-case basis.

The pertinent legislative history illustrates that, in 1934-35, all involved in the legislative process of what would ultimately become Section 9(b) were well aware that Congress had chosen the Board to make bargaining-unit determinations; no modification of the original Section 9(b) language was necessary to clarify that point. Therefore, the "in each case" language, which was added to the final version of Section 9(b) for "clarification," was added to the Section for some reason other than choosing the Board as the unit determiner. The real reason, according to the plain meaning of the "in each case" phrase, was to instruct the Board to make bargaining-unit determinations based upon the facts of each individual case.

In the past, the Board and the courts have all concluded that Section 9(b) (and other, similar statutes) requires the Board to make unit determinations on a case-by-case basis and further have held that many of the eight units designated by the new Rule are, in fact, sometimes inappropriate, depending on the circumstances of the case. Therefore, the Board, by exercising (out of futility) its rulemaking authority, has substituted a quick-fix

resolution of bargaining-unit disputes for the required case-by-case determinations that allow each party to show which units are appropriate in any facility. Only in individual proceedings can the board properly weigh the competing claims for particular units.

Further, the Rule is improper in light of Congress' enunciated concern that the health-care industry is vulnerable to labor unrest and that, therefore, the Board should give due consideration to preventing proliferation of bargaining units in this industry. A health-care rule mandating eight units fails to take into account Congress' express concern. For these reasons, the judgment of the United States Court of Appeals for the Seventh Circuit should be reversed.

ARGUMENT

I.

CONTRARY TO THE DECISION OF THE COURT OF APPEALS, THE BOARD'S NEW EIGHT-UNITS RULE VIOLATES THE STATUTORY MANDATE CONTAINED IN SECTION 9(b) OF THE NATIONAL LABOR RELATIONS ACT THAT COLLECTIVE-BARGAINING UNITS ARE TO BE DETERMINED FROM THE FACTS IN EACH CASE

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), provides the following:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit,

craft unit, plant unit, or subdivision thereof:

....

The language of the statute appears to be unambiguous: The Board is to determine the appropriateness of bargaining units based upon the facts of each individual case.

While Section 6 of the Act allows the Board of promulgate rules and regulations as it deems necessary to effectuate the policies of the Act, 29 U.S.C. § 156, St. Francis, in agreement with the Petitioner (see Petition for Certiorari, at 13), submits that Section 9(b) is a limitation on the Board's ability to promulgate a Rule relating to determining appropriate bargaining units. Read together, the two sections provide that the Board may promulgate rules and regulations regarding determination of appropriate bargaining units so long as such rules allow for unit determinations to be made on a case-by-case basis.

The Board exceeded its rulemaking authority under Section 6 in promulgating a Rule that eight, and only eight, units shall be appropriate for all acute-care hospitals.² Such a rule does not allow for unit determinations to be made on the required case-by-case basis.

² The Board's Rule provides that, "except in extraordinary circumstances," the following eight units "shall be appropriate units, and the only appropriate units" for all acute-care hospitals:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.

(Continued on following page)

Although the Board did provide that it would not apply the rule in "extraordinary circumstances," it emphasized that such extraordinary circumstances would be extremely rare. The Board listed a number of factors that it will not consider to be such "extraordinary circumstances."³ These excluded factors are basically the same

(Continued from previous page)

- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All other nonprofessional employees.

29 C.F.R. § 103.30, The National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-48 (1989).

³ These factors will not be considered by the Board as "extraordinary circumstances":

- (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of out-patient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals);
- (2) Increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multicompetent worker, increased use of "team" care, and cross-training of employees;

(Continued on following page)

criteria the Board formerly used in making case-by-case bargaining-unit determinations. By eliminating these factors as bases for challenging unit appropriateness, the Board has effectively precluded any meaningful challenge to its eight-units rule, thereby subverting the statutory mandate that all unit determinations be based on a case-by-case analysis.

While the Board may not enlarge its authority beyond the scope intended by Congress, the Board may, where restrictive intention is not shown, adopt rules and regulations to carry out its myriad functions in a manner consistent with the fulfillment of the purposes of the Act. *Department & Specialty Store Employees Union v. Brown*, 284 F.2d 619, 627 (9th Cir. 1960). Here, however, restrictive intention is shown by Congress' inclusion of the "in each case" language in Section 9(b).

(Continued from previous page)

- (3) The impact of nation-wide hospital "chains";
- (4) Recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs;
- (5) The effects of various governmental and private cost-containment measures; and
- (6) Single institutions occupying more than one contiguous building.

Notice of Proposed Rulemaking, 53 Fed. Reg. 33,932 (1988).

A. The "in each case" Language Contained in Section 9(b) Requires the Board to Make Unit Determinations Based upon the Facts of Each Individual Case; it does not Relate to the Congressional Choice of Who Should Make Unit Determinations.

Section 9(b) provides that the Board shall decide "in each case" the unit appropriate for collective bargaining. 29 U.S.C. § 159(b) (1973). However, as originally drafted, Section 9(b) did not contain the "in each case" language. The Bill as introduced by Senator Wagner provided as follows:

(b) The Board shall decide whether, in order to effectuate the policies of this Act, the unit appropriate for the purpose of collective bargaining shall be the employer unit, craft unit, plant unit, or other unit.

S. 1958, 74th Cong., 1st Sess. 9(b) (1935), *reprinted in* Legislative History of the National Labor Relations Act, 1935, Vol. I at 1295 (1985) (hereinafter Leg. Hist.).⁴

⁴ Senator Wagner originally proposed the "Labor Disputes Act," S. 2926, 73d Cong., 2d Sess. 1 (1934), Leg. Hist., Vol. I at 1, predecessor to the National Labor Relations Act, during the 73d Congress. Therein, at Section 207(a), Senator Wagner provided that "[t]he Board shall decide whether eligibility to participate in elections shall be determined on the basis of employer unit, craft unit, plant unit, or other appropriate grouping." S. 2926, 73d Cong., 2d Sess. 19 (1934), Leg. Hist., Vol. I at 11. Thus, as early as 1934, Senator Wagner intended that the Board was to determine appropriate bargaining units. Although this Bill was never enacted, it served as a guide to the National Labor Relations Act introduced and passed the following year.

The "in each case" language did not appear in this statute until May 1, 1935, when Section 9(b) was revised to read as follows:

(b) The Board shall decide *in each case* whether, in order to effectuate the policies of this Act, the unit appropriate for the purpose of collective bargaining shall be the employer unit, craft unit, plant unit, or other unit.

S. Rep. No. 573, 74th Cong., 1st Sess. 12 (1935), Leg. Hist., Vol. II at 2291 (emphasis added).

In the present case, the court of appeals held that the "in each case" language was added to indicate that the Board, not the employees, employer, or Congress, was to determine the appropriate unit for collective bargaining. *American Hospital Ass'n v. NLRB*, 899 F.2d at 656. However, from its inception, the original language of Section 9(b) had indicated that it was to be the Board that would determine the appropriate bargaining unit. Both the version introduced in 1934 before the 73d Congress in the "Labor Disputes Act," and the original version introduced in 1935 before the 74th Congress, clearly indicated that unit determinations were to be made by the Board.

The fact that it was obvious to everyone who read the original language of the proposed statute that Congress had decided to empower the Board to make bargaining-unit determinations, is evidenced by the number of associations and other interest groups that wrote to and appeared before Congress to protest the congressional choice of the Board as the bargaining-unit determiner. Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 302, 736-56 (1935), Leg. Hist., Vol. II at 1688, 2122-42.

Many of these interest groups argued that the employees themselves, not the Board, should have the right to determine their own units. Typical is the comment of R.W. Ayres, Chairman of the Employee's Representation Committee with Northwestern Bell, who opposed the portion of the pre-"in each case" Section 9(b) allowing the Board to determine the appropriate unit for collective-bargaining purposes; rather, said Mr. Ayres, "the employees should have the right to set up their own units for collective bargaining without interference from any outside force." As a result, Mr. Ayres declared, "we object to Section 9(b) in its entirety." Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 737 (1935), Leg. Hist., Vol. II at 2123.

As indicated by such comments, it was clear to everyone involved, from the original language of Section 9(b) (which lacked the "in each case" language) that Congress had decided to establish the Board, not the employees or anyone else, to decide appropriate bargaining units. It strains logic to imagine that Congress would have thought it necessary to *modify* the original version of Section 9(b) so as to reflect a choice for the Board as the bargaining-unit determiner, as held by the Seventh Circuit, when all involved in the legislative process certainly understood the original language to already make that choice.

An examination of the testimony of Secretary of Labor Frances Perkins, who testified in 1935 before the Senate Education and Labor Committee, sheds further light on the true purpose of the "in each case" language. At the conclusion of her testimony (which consisted primarily of arguing why the Labor Board ought to be made

a part of the Department of Labor), Secretary Perkins indicated that she had a "number of other small amendments" to make to the Act "for the sake of *clarity*" and for "*clarification* of the duties and powers of the Board." Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 66 (1935), Leg. Hist., Vol. I at 1442 (emphasis added). One of these "small amendments" proposed was the inserting of the "in each case" language in Section 9(b). Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 69 (1935), Leg. Hist., Vol. I at 1445; Hearings on H.R. 6288 before the House Comm. on Labor, 74th Cong., 1st Sess. 284 (1935), Leg. Hist., Vol. II at 2758.

Secretary Perkins did not further expand on the reason for the language change. However, since those who had read the original Section 9(b) language already knew that that language chose the Board to make bargaining-unit determinations, there was certainly no need for "clarification" (Secretary Perkins' word) to make that point. Therefore, "clarification" must have referred to clarifying some other point.

In addition, Secretary Perkins' reference to "clarifying" the "duties and powers of the Board" suggests the true purpose of Secretary Perkins' amendment. The use of the word "duties" suggests actions the Board would be required to take. The Seventh Circuit's interpretation of the "in each case" phrase is, therefore, incorrect, since Congress' act of choosing the Board over employees does not connote a "duty" of the Board itself. On the other hand, the obligation to make unit determinations in each individual case would certainly be considered a "duty" of the Board.

In spite of the various reasons offered by the Seventh Circuit to explain the "in each case" language, it can surely be said that one of the reasons was *not* that Congress wanted to clarify Section 9(b) so that everyone would understand that the Board was responsible for making the decision as to unit appropriateness. The original pre-enactment Section 9(b) language chose the Board; therefore, it was unnecessary to make any other changes in Section 9(b) in order to clarify this choice. Since the "in each case" language logically does not relate to the congressional choice of who should make unit determinations, it must relate to some other purpose: *how* the Board was to make unit determinations.

A plain reading of the "in each case" phrase, and in light of Secretary Perkins' comments and the legislative history of Section 9(b) as a whole, indicates that the "in each case" language was inserted to clarify that it was the Board's duty to make unit determinations based upon the facts of each individual case.

Petitioner and St. Francis' position is further supported by the Committee Report that accompanied the House version of the Act. H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935), Leg. Hist., Vol. II at 2930. Therein, the House explained that it chose the Board to make bargaining-unit determinations because such determinations had to be made "in each individual case." *Id.* Stated the House Report:

Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit,

employer unit, or other unit. *This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination.*

Id. (emphasis added).

The Seventh Circuit did not give the "in each individual case" phrase its complete meaning when it said – referring to the House's explanation – "[a]ll this appears to mean is that unit determination is a task meet for the Board rather than for either the Congress or the employees themselves." *American Hospital Ass'n v. NLRB, et al.*, 899 F.2d at 656. To adopt the Seventh Circuit's rationale would render the above-emphasized portion of the House's explanation meaningless, since the latter part of that phrase states that the Board is to make unit determinations. The comment makes two points, (1) unit determinations are to be made on a case-by-case basis, and (2) the Board is to make such determinations. The Seventh Circuit acknowledges the latter point, but not the former. It is a general rule of statutory interpretation that a court should not construe a statute in a way that makes words or phrases meaningless, redundant, or superfluous. *Zimmerman v. North American Signal Co.*, 704 F.2d 347, 353 (7th Cir. 1983). Instead, a court should interpret a statute in a light that gives full effect to the language of the statute. See *Department & Specialty Store Employees Union v. Brown*, 284 F.2d 619, 626 (9th Cir. 1960). The Seventh Circuit's rationale renders the House's statement that "[t]his matter is obviously one for determination in each individual case," meaningless.

Therefore, the Seventh Circuit erred in finding that the Board is not required to make unit determinations based on the facts of an individual case.

B. The Court of Appeals' Holding that Section 9(b) Does Not Require Unit Determinations to be Made on a Case-by-Case Basis is Contrary to Years of Established Case Law.

For over fifty-five years, the Board and the courts have interpreted Section 9(b) to mandate that bargaining units be determined on a case-by-case basis. *See, e.g., NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944); *NLRB v. Esquire, Inc.*, 222 F.2d 253, 256 (7th Cir. 1955); *Kalamazoo Paper Box Corp.*, 136 N.L.R.B. 134, 137 (1962). In *St. Francis II*, the Board reiterated its understanding of the case-by-case mandate contained in Section 9(b):

The analysis we set forth today establishes neither a minimum nor a maximum number of appropriate bargaining units, but rather permits the determination to be made on the facts of the particular facility involved. We believe that this approach comports with Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis.

271 N.L.R.B. 948, 951 n. 17 (1984).⁵

⁵ Section 9(b) applies to unit determinations for all bargaining units, not just those in the health-care industry. The Board's longstanding practice has been to make unit determinations in each individual case, giving consideration to the unique facts of each situation. It is well recognized that a court

(Continued on following page)

Likewise, the Eighth Circuit has held that bargaining-unit determinations must be made based upon the facts in each case. *NLRB v. May Department Stores Co.*, 146 F.2d 66, 68 (8th Cir. 1944). *See also NLRB v. Metal Container Corp.*, 660 F.2d 1309, 1313 (8th Cir. 1981) (craft unit determinations are to be made on a case-by-case basis after weighing all of the relevant factors). The Sixth Circuit has held that "an appropriate unit is a question of fact to be determined by the Board upon the facts of each case." *Metropolitan Life Insurance Co. v. NLRB*, 330 F.2d 62, 65 (6th Cir. 1964), *vacated on other grounds*, 380 U.S. 525 (1965).

In *Kalamazoo Paper Box Corp.*, 136 N.L.R.B. 134, 137 (1962), the Board stated that its obligation under the statute was to enforce the mandate of Congress that the unit appropriate for the purposes of collective bargaining should be decided in each case. In addition, the Board stated the following:

Because the scope of the unit is basic to and permeates the whole of the collective-bargaining relationship, each unit determination, in order to further effective expression of the statutory purposes, must have a direct relevancy to the circumstances within which collective bargaining is to take place. [citation omitted] For, if the unit determination fails to relate to the factual situation with which the parties must deal,

(Continued from previous page)

may accord great weight to the longstanding interpretation placed upon a statute by the agency charged with its administration. *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 274-75 (1974); *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381 (1969).

efficient and stable collective bargaining is undermined rather than fostered.

To accord automatically to a subgroup of employees such as truck drivers, severance from a larger established and stable bargaining unit merely on the basis of the existence of the traditional job classification and a request for a separate unit encompassing such classification, does not, in our opinion, adequately discharge this basic and far-reaching responsibility placed upon the Board by Congress. A title or classification in common usage does not necessarily establish that separate special interests exist and are preponderant. This can be determined only by making an informed judgment based upon an analysis of the factual circumstances bearing upon the distinguishing factors present in each case.

Id. at 137-38.

Put simply, the Board, in promulgating its eight-units Rule, has departed from its longstanding interpretation of Section 9 (b) that appropriate bargaining units must be determined based upon the facts of each individual case.

Therefore, the Seventh Circuit erred in finding that the Board is not required to make unit determinations based on the facts of each individual case.

C. Other Statutes Containing the "in each case " Language have been Interpreted to Require Individual, Case-by-Case Determinations.

Other statutes, such as the Postal Reorganization Act (hereinafter PRA), 39 U.S.C. § 1202,⁶ that contain the "in

⁶ "The National Labor Relations Board should decide in each case the unit appropriate for collective bargaining purposes in the Postal Service. . . ."

each case" language have been interpreted to require the Board to determine the appropriateness of bargaining units in each individual case. In *United States Postal Service*, 208 N.L.R.B. 948, 952 (1974), the Board stated that "the congressional mandate to this Board in the comprehensive PRA Legislation was to determine 'in each case the unit appropriate for collective bargaining in the postal service.' "

The legislative history of the Postal Reorganization Act indicates that Congress modified Section 1202 to delete the reference restricting appropriate collective-bargaining units to national craft units and to provide instead that the National Labor Relations Board would decide "in each case" the units appropriate for collective bargaining. Staff of Senate Comm. on Post Office and Civil Service, S. 622-3, 93d Cong., 1st Sess., Explanation of the Postal Reorganization Act and Selected Background Material 155-56 (Comm. Print 1973). In settling on the proposal that the Board determine appropriate units for collective-bargaining purposes, the conference committee stated its intent that the Board determine appropriate units for collective bargaining in the Postal Service on the basis of the same criteria applied by the Board in the private sector. *Id.* The conference committee deemed it desirable to leave the determination of appropriate bargaining units entirely to the judgment of the Board rather than to pre-determine such matters in any way. *Id.*

In light of the above statements of congressional intent, the Board determined that Congress did not indicate a desire that it depart from its traditional community-of-interest approach. *United States Postal Service*, 208 N.L.R.B. at 953. Thus, the Board considered each of the

petitions pending before it on a case-by-case basis, examining in each case factors unique to the postal service along with factors such as geographic proximity, employee interchange, and distinctiveness of job classifications. *Id.* at 954.

Thus, another statute – one virtually identical to 29 U.S.C. §159(b), enacted by Congress for the purpose of determining bargaining units – has been interpreted by the Board to mean that bargaining-unit determinations are to be made on a case-by-case basis.

Consequently, the Seventh Circuit erred in finding that Section 9(b) of the Act does not require the Board to make unit determinations based on the facts of each individual case.

D. The Board's new Rule deprives the Board of its Congressionally Mandated Flexibility.

The Seventh Circuit stated that the word "case" means a "proceeding" and that the term is broad enough to cover a rulemaking proceeding as well as an adjudicated one. The Seventh Circuit also stated that "case" can be an industry or a sub-set or sub-market of an industry; it need not be a particular dispute between a particular employer and a particular union at a particular plant or establishment. *American Hospital Ass'n v. NLRB, et al.*, 899 F.2d at 656. To carry the Seventh Circuit's argument to its logical end, the Board could conceivably promulgate a rule in the aluminum-smelting industry (the industry being a single case, according to the Seventh Circuit's definition), or the tire and rubber industry, or the textile industry, or any other industry, designating the number

of appropriate units in each of these industries, or as the Seventh Circuit has put it, in each such case. Such rules would, according to the Seventh Circuit's rationale, comport with the congressional directive that collective-bargaining units be determined on a case-by-case basis. However, this is not what Congress intended when it instructed the Board to determine collective-bargaining units based upon the facts of each individual case.

Congress intended that the Board exercise flexibility in determining bargaining units based on the facts in each case. The Fourth Circuit in *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191, 194 (4th Cir. 1982), indicated its understanding that Congress intended the Board to maintain flexibility in determining appropriate bargaining units. The Seventh Circuit also has recognized the Board's need to maintain flexibility in determining appropriate bargaining units. *NLRB v. Esquire, Inc.*, 222 F.2d 253, 256 (7th Cir. 1955). In *Esquire, Inc.*, the Seventh Circuit also stated that, given the multiplicity of factors in determining an appropriate bargaining unit, it would be impossible for the Board to formulate rules that could be rigidly applied in all situations. *Id.* Likewise, this Court has pointed out the difficulty inherent in using inflexible rules to determine appropriate bargaining units, due to the wide variations in employee make-up and the complexities of modern industrial society. *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944). See also *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974) (expressed doubt as to the validity of developing a rule that could define all managerial employees).

In 1935, Congress was informed of the need to maintain flexibility in determining bargaining units by

Chairman of the National Labor Relations Board Francis Biddle:

It is impossible, however, to lay down a definite rule for the determination of the appropriate unit, for such an attempt would result in rigidity and confusion. The whole system of industrial control and development depends on flexibility, and such considerations must be taken into account as the question of management and supervision, routine employment contracts, existing plans of collective bargaining, and the distinctiveness of the occupation.

Hearings on S. 1958 before the Senate Comm. on Education and Labor, 74th Cong., 1st Sess. 83 (1935), Leg. Hist., Vol. I at 1459. Indeed, Secretary Perkins, who authorized the "in each case" language, expressed the importance of flexibility in the Act. Hearings on H.R. 6288 before the House Comm. on Labor, 74th Cong., 1st Sess. 283 (1935), Leg. Hist., Vol. II at 2757. The Board's Rule eliminates the flexibility needed to determine bargaining units appropriate to the factual circumstances of each case.

The Board's need to maintain flexibility in determining bargaining units is evident in the statutory language that units are to be determined "in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter." 29 U.S.C. §159(b) (1973). An individualized determination of bargaining units appropriate in a particular facility will better assure employees the " 'fullest freedom in exercising . . . [their] rights.' " *American Hospital Ass'n v. NLRB, et al.*, 718 F. Supp. 704, 712 (N.D. Ill. 1989) (quoting 29 U.S.C. §159(b)). The history of labor relations in this country reflects the

wisdom of Congress' choice for a dynamic process requiring such flexibility with regard to changing circumstances, company to company.

Therefore, the Seventh Circuit erred in finding that Section 9(b) of the Act does not require the Board to make unit determinations based on the facts of each individual case.

E. The Substance of the Board's new Rule is Contradicted by the Board's own Decisions and Those of the Various Courts of Appeals.

The Board's Rule that the designated eight units are always appropriate in the acute-care health industry (barring "extraordinary circumstances" that are virtually impossible to find), flies in the face of the Board's own past determinations and those of other courts of appeals. These cases establish that, in fact, these eight units are *not* always appropriate in every acute-care hospital. See, e.g., *NLRB v. Frederick Memorial Hospital, Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (unit composed of registered nurses only, found to be inappropriate); *Long Island Jewish-Hillside Medical Center v. NLRB*, 685 F.2d 29, 34-35 (2d Cir. 1982) (unit of registered nurses limited to one of several divisions of a city-wide hospital found inappropriate); *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 809-12 (9th Cir. 1982) (unit composed of registered nurses only, found inappropriate); *Beth Israel Hospital and Geriatrics Center v. NLRB*, 677 F.2d 1343, 1345 (10th Cir. 1981), *cert. denied*, 459 U.S. 1025 (1982) (unit limited to registered nurses only, found inappropriate); *Vicksburg Hospital, Inc. v. NLRB*, 653 F.2d 1070, 1074-75

(5th Cir. 1981) (unit composed of combined service, maintenance, and technical employees found to be appropriate); *St. John of God Hospital, Inc.*, 260 N.L.R.B. 905, 906 (1982) (unit composed of registered nurses and technical employees found appropriate); *Community Health Services, Inc.*, 259 N.L.R.B. 362, 363 (1981) (unit composed of all professional employees found appropriate); *Appalachian Regional Hospitals, Inc.*, 233 N.L.R.B. 542, 543-44 (1977) (combined unit of service, maintenance, and technical employees found to be appropriate); *Kaiser Foundation Health Plan of Colorado*, 230 N.L.R.B. 438, 439 (1977) (unit of registered nurses only, found to be inappropriate); *Sutter Community Hospitals of Sacramento*, 227 N.L.R.B. 181, 184 (1976) (separate units of service and maintenance employees found to be inappropriate).

Therefore, the Seventh Circuit erred in upholding the Board's eight-units Rule.

II.

EVEN IF A RULE PRESUMING EIGHT UNITS MIGHT OTHERWISE BE APPROPRIATE, THE BOARD'S MAKING SUCH A PRESUMPTION VIRTUALLY IRREBUTTABLE VIOLATES THE SECTION 9(b) "IN EACH CASE" REQUIREMENT.

Although the Seventh Circuit did not believe that Section 9(b) required the Board to make unit determinations on an individual case-by-case basis, the Court also held that such a requirement, to the extent it exists, has been satisfied by the Board's formal rulemaking process. The Seventh Circuit evidently concluded that the gathering of evidence and testimony at the rulemaking hearings satisfied any such case-by-case requirement. However,

the relatively small sampling of evidence adduced at these hearings pales in comparison to the specific evidence adduced at the numerous past trials and hearings held over the years to determine appropriate bargaining units in the acute-care health industry. Contrary to the vast compilation of evidence adduced at these adjudicatory hearings – which conclude that these eight units are not always appropriate – the Board established that eight units are always appropriate, based on its sampling of evidence adduced during formal rulemaking.

It is a fundamental precept of American jurisprudence that true facts are best elicited when there is an adversarial hearing, with opportunity for cross-examination. See, e.g., *Sward, Values, Ideology And the Evolution of the Adversary System*, 64 Ind. L.J. 301, 316 (1989). In numerous adjudicatory hearings in the past, and regardless of what standard was utilized by the Board or by the particular court, the Board or the court found, as did the courts of appeals, that craft units or registered-nurse-only units were not appropriate in certain circumstances. However, the present Board, based upon the "truths" that it ascertained during the non-evidentiary "hearings" (consisting of statements and arguments by various special interests) held prior to formulating its Rule, determined that craft units and registered-nurse-only units were always appropriate in the health-care industry.

A fact-specific adjudication with cross-examination will always elicit the truth better than a mere study, no matter how broad. The Board's new Rule creates a

presumption that is virtually irrebuttable.⁷ It defies logic that the Board would have the power and authority to create a Rule incapable of contradiction by any employer in the health-care industry, when that Rule is based on "evidence" that is, by its very nature, not of the highest reliability (based on a study, instead of on fact-specific adjudicatory hearings with right of cross-examination) and when the most reliable evidence (that gleaned from such fact-specific adjudications by the Board over the years) itself contradicts the very substance of the new Rule!

It must be concluded that, at the very least, such a presumption, being virtually irrebuttable, does not satisfy the individual-case requirement of Section 9(b). Thus, even if the Board's presumption of eight units in the acute-care health industry is otherwise appropriate, those provisions of the new Rule making that presumption

⁷ The Court has previously upheld rulemaking by various federal agencies where those agencies have included within their rule a "safety valve" that allows an individual or entity affected by the Rule, a meaningful opportunity to demonstrate that such individual or entity should be excepted from the rule's application because of special circumstances. *See, e.g., E.I. duPont de Nemours & Co. v. Train*, 430 U.S. 112, 128 (1977); *Permian Basin Area Rate Cases*, 390 U.S. 747, 771-72 (1968); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40-41 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 204-05 (1956); *National Broadcasting Co. v. United States*, 319 U.S. 190, 207, 225 (1943). By contrast, the NLRB's eight-units Rule does not provide affected parties a meaningful opportunity to challenge the Rule's application, since it provides that virtually all of the factors successfully relied on by parties to challenge NLRB unit determinations in the past are no longer viable.

irrebuttable must be struck down. A rule establishing a rebuttable presumption of eight units would at least allow the particular health-care party to rebut the determination as to the appropriateness of the petitioned-for unit by presenting evidence sufficient to overcome the presumption, and such evidence could certainly include the factors considered by the Board and the courts for the past 13 years.

In short, the Board's eight-units Rule, as constituted, effectively creates an irrebuttable presumption of unit appropriateness irrespective of circumstances that would justify a lesser number of units in a particular case. Therefore, the Board's eight-units Rule should be adjudged invalid.

III.

THE BOARD'S EIGHT-UNITS RULE IS CONTRARY TO CONGRESS' ADMONITION TO AVOID UNDUE PROLIFERATION OF BARGAINING UNITS IN THE HEALTH-CARE INDUSTRY.

In 1974, Congress amended the National Labor Relations Act to cover all private health-care institutions, including non-profit hospitals. Act of July 26, 1974, Pub. L. 93-360 §1(a),(b), 88 Stat. 395. However, due to the fact that health-care institutions provide care for the sick, the aged, and the infirm, Congress sought to provide certain restrictions on unit proliferation in the health-care industry, since patient treatment cannot tolerate the interruptions occasioned by labor disputes.

Because of such concerns, Senator Taft sought to limit the number of bargaining units appropriate in the

health-care industry to five.⁸ S. 2292, 93d Cong., 1st Sess. (1973), *reprinted in* Legislative History of the Coverage of Non-Profit Hospitals under the National Labor Relations Act, 1974, at 457-58. However, Senator Taft withdrew this bill and opted instead for a compromise, an admonition in both the House and Senate Committee Reports expressing Congress' concern that the Board give due consideration to preventing proliferation of bargaining units in the health-care industry. S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). Legislative history indicates that Senator Taft withdrew his original bill because of concerns raised that the five-units "Rule" was too rigid and deprived the Board of the flexibility needed to determine units on a case-by-case basis. Legislative History of the Coverage of Non-Profit Hospitals under the National Labor Relations Act, 1974, at 113-14.

The Board and the Courts of Appeals have recognized the Board's obligation to adhere to the congressional admonition in considering the appropriateness of bargaining units in the health-care industry. See, e.g., *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *St. Francis Hospital*, 271 N.L.R.B. 948, 951 (1984).

The Rule as promulgated by the Board fails to pay heed to the congressional directive to give due consideration to avoiding proliferation of bargaining units in the

⁸ 1) All professionals; 2) all technical employees; 3) all clerical employees; 4) all service and maintenance employees; and 5) guards.

health-care field. The Rule that eight units are appropriate for all acute-care hospitals throughout the country actually promotes unit proliferation, since a lesser number of units would almost never be found appropriate. This concern was aptly stated by Judge Zagel in the district court below:

There are general directives which the Board must follow whenever it makes a unit appropriateness decision in whatever the industry. But Congress drew attention to health care by adding another concern, which must be addressed by the Board in certifying bargaining units in that industry. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, it must use the means least likely to cause unit proliferation to achieve their objective. Although we can agree with the Board that the eight units they establish are appropriate and in many instances may match the natural divisions among the employees and health care institutions, we can envision other divisions, perhaps fewer divisions, in the varied health institutions which would be equally reasonable.

American Hospital Ass'n v. NLRB, 718 F. Supp. 704, 714 (N.D. Ill. 1989).

Consequently, the Board's eight-units Rule should be adjudged invalid, as the Rule promotes unit proliferation in the health-care field.

CONCLUSION

This Honorable Court should reverse the judgment of the United States Court of Appeals for the Seventh Circuit and hold that the Board's inflexible Rule for acute-care hospitals does not satisfy the case-by-case requirement contained in Section 9(b) of the Act, nor does it give due consideration to Congress' admonition to avoid undue proliferation of bargaining units in the health-care industry. As such, the Rule is invalid and should be stricken.

In the alternative, if this Court should uphold the presumption of eight units, it should nonetheless hold that the present eight-units Rule is invalid, in that the Rule does not allow parties to rebut the presumption with the factors relied upon by employers for the last 13 years.

In light of the foregoing, this Honorable Court should reverse the judgment of the Seventh Circuit and hold the Board's eight-units Rule invalid.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION

v.

NATIONAL LABOR RELATIONS BOARD, *et al.*

On Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

**BRIEF FOR THE SOCIETY FOR
HUMAN RESOURCE MANAGEMENT AS
AMICUS CURIAE SUPPORTING PETITIONER**

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

No. 90-97

AMERICAN HOSPITAL ASSOCIATION

v.

NATIONAL LABOR RELATIONS BOARD, *et al.*On Writ of Certiorari to the
United States Court of Appeals
for the Seventh CircuitBRIEF FOR THE SOCIETY FOR
HUMAN RESOURCE MANAGEMENT AS
AMICUS CURIAE SUPPORTING PETITIONER

CONSENT TO FILING

This *amicus curiae* brief is filed pursuant to Supreme Court Rule 37.2, with the written consent of all parties in interest. Letters of consent have been filed with the Clerk of this Court.

INTEREST OF THE AMICUS CURIAE

The Society for Human Resource Management ("SHRM" or the "Society") is the world's largest association of personnel and human resources professionals, representing over 46,000 individuals and entities in business, government and education. The primary goal of the Society and its members is to further effective personnel and human resource management. Accordingly, SHRM has a keen interest in the development and enforcement of the myriad laws and regulations governing every aspect of employment.

A substantial number of the Society's members either work in or have significant connections with the health

care industry. In turn, as the major professional human resources organization in the nation, SHRM is vitally concerned with the orderly evolution of laws governing labor-management relations in acute-care hospitals and other health care institutions. SHRM has long recognized its special responsibility to support and encourage compliance with the National Labor Relations Act ("NLRA" or the "Act"), 29 U.S.C. §§ 151-68 (1982). And in that regard, the Society believes that this case presents the Court with an excellent opportunity to strike a careful balance between the fundamentally compatible dual goals of section 9(b) of the Act—namely, providing the National Labor Relations Board ("NLRB" or the "Board") with the procedural flexibility to protect the organizational rights of health care workers, while simultaneously preserving the right of employers and other interested parties to make case-specific showings with respect to the appropriateness of proposed collective bargaining units. On that basis, SHRM urges this Court to reverse the judgment of the Court of Appeals.¹

ISSUE PRESENTED

May the National Labor Relations Board promulgate and enforce *per se* unit determination rules in the health care industry, thereby foreclosing health care employers from presenting evidence "in each case" regarding the appropriateness of proposed collective bargaining units?

¹ The Society has repeatedly indicated for the record its opposition to the "unit determination rules" that are at issue in this case. SHRM filed substantive comments with the NLRB during the rule-making proceedings and urged the Board to continue to decide representation cases in the health care industry on an "adjudicated," case-by-case basis. In turn, through this *amicus* brief, the Society now renews its position that the Board cannot ignore the requirements of section 9(b) of the Act and the congressional "non-proliferation mandate" accompanying the Health Care Amendments Act of 1974 by promulgating and enforcing *per se* unit determination rules for application in cases involving acute-care hospitals.

SUMMARY OF ARGUMENT

1. By its terms, section 9(b) of the Act provides that the Board "*shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof.*" 29 U.S.C. § 159(b) (1982) (emphasis supplied). This plain and simple statutory mandate requires the NLRB to resolve disputes over the "appropriateness" of proposed collective bargaining units on an employer-specific, case-by-case basis. It broadly embodies, moreover, Congress' common-sense recognition that "[wide] variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit." *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

2. More than sixteen years ago, Congress extended the NLRA's protections to the employees of private, non-profit hospitals by adopting the Health Care Amendments Act of 1974 (the "1974 Amendments"), Pub. L. No. 93-360, 88 Stat. 395 (1974) (amending 29 U.S.C. §§ 151-68 (1973)). It did so, however, against the background of a broad legislative consensus "that the hospital industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that 'Hospital care is not storable.'" *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 411 (9th Cir. 1979) (quoting S. Rep. No. 766, 93d Cong., 2d Sess. 39 (1974) (individual views of Sen. Dominick), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3953). Accordingly, the House and Senate committee reports accompanying the 1974 Amendments included identical language specifically directing the NLRB to *prevent* the proliferation of bargaining units in health care institutions. *See* S. Rep. No. 766, 93d Cong., 2d Sess. 5

(1974), reprinted in 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974).

As the circuit courts have repeatedly held, "[b]ecause this legislative comment to nonproliferation is explicit in the legislative history leading to the repeal of the prior exemption [of nonprofit hospitals from the coverage of the NLRA], it is binding on the NLRB and must be implemented by it." *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982). Yet the express "nonproliferation mandate" is not the only significant feature of the legislative history of the 1974 Amendments. The Ninety-Third Congress had previously allowed two alternative proposals to die in committee. The first, S. 794, would simply have repealed the preexisting exemption outright; while the second, S. 2292, would have provided for a maximum of five "presumptively appropriate" bargaining units in the health care industry—namely, all professional employees, all technical employees, all clerical employees, all service and maintenance employees and all guards.

As demonstrated below, the only fair inference to be drawn from Congress' failure to enact either proposal—and its later adoption of compromise legislation—is that it considered *and then rejected* a procedural departure from the existing, statutorily mandated "case-by-case" approach to Board resolution of unit determination disputes. Thus, contrary to the Respondent's repeated assertions below, the legislative history of the 1974 Amendments and Congress' purported "rejection" of S. 2292 suggest that the statute's draftsmen meant for the Board to continue to decide representation cases on the basis of highly variable, case-specific records—i.e., consistent with the express terms of section 9(b) of the Act.

3. The NLRB's new health care bargaining unit determination rules, 54 Fed. Reg. 16,347-48 (1989) (hereinafter cited as "Final Rule") (codified at 29 C.F.R.

§ 103.30 (1990)), contravene both the "in each case" procedural requirement of section 9(b) *and* the "nonproliferation mandate" accompanying the 1974 Amendments. First, as the Board itself acknowledges, the new rules effectively foreclose any future case-specific adjudications of the "appropriateness" of proposed bargaining units. Indeed, they do so by specific design.² Second, the new rules inherently *encourage*, rather than prevent, the "proliferation" of bargaining units in the health care industry. Standing alone, the "nonproliferation mandate" appearing in the House and Senate committee reports forecloses the Board from establishing, either by rule or adjudication, definitive "presumptions" with respect to bargaining unit "appropriateness." *See, e.g., NLRB v. Mercy Hospital Association*, 606 F.2d 22, 27-28 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980). Yet as a threshold matter, the Board's unit determination rules obviously accomplish precisely this prohibited purpose. Equally important, the new rules by their very nature contemplate bargaining unit "proliferation." In no other identifiable "industry" has the Board been will-

² *See, e.g.,* Second Notice of Proposed Rulemaking, 53 Fed. Reg. 33,933 (1988) (hereinafter cited as "NPR II") ("[T]he Board has made a judgment that, in this area of establishing appropriate units, '[d]etailed analyses of all the facts of the particular case are just not that enlightening.'" (quoting Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981))). The new rules include a "catchall" exception to their general applicability and provide that, "[w]here extraordinary circumstances exist, the Board shall determine appropriate units by adjudication." 29 C.F.R. § 103.30(b) (1990). The Board has made plain, however, that its "intent is to construe the extraordinary circumstances exception narrowly." NPR II, 53 Fed. Reg. at 33,932. For example, NPR II lists a number of circumstantial "variations" among acute-care hospitals that apparently will not, "alone or in combination, constitute[] 'extraordinary circumstance[s]' justifying an exception from the rule." *Id.* The Board has expressly indicated, moreover, that "*none* of the arguments raised in the course of the rulemaking procedure" will be sufficient, if asserted anew in future unit determination cases, to justify invocation of the "extraordinary circumstances" exception. *Id.* (emphasis supplied).

ing to certify as "appropriate" eight definitionally distinct bargaining units. It now seeks to do so as a matter of course—withstanding Congress' expressed concern that "[h]ealth-care institutions must *not* be permitted to go the route of other industries . . . in this regard." 120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied).

4. From the unique perspective of this *amicus*, however, the dispositive point is that the section 103.30 unit determination rules are broadly inconsistent with the spirit, as well as the letter, of the NLRA itself and the 1974 Amendments. As a practical matter, the Board's promulgation of rules that establish the same, *per se* bargaining unit structure at each general acute-care hospital in the nation seals shut the doors of the federal courts to health care employers seeking to question and appeal effectively NLRB bargaining unit determinations. Given the highly unstable, politicized environment in which the Board operates,³ the right to appeal unit determinations has become an increasingly important check and balance on agency discretion.⁴ The Board's new rules would dispense with individualized, case-by-case determinations of bargaining unit "appropriateness" in health care institutions, thereby foreclosing meaningful appellate review of individual unit determinations in one of the nation's largest industries. Thus, in the Society's view, the new approach eliminates the *only* meaningful check on agency discretion in this area and, in turn, al-

³ The Board has been plagued by remarkable political instability since the adoption of the 1974 Amendments. Indeed, twenty-two different individuals—thirteen Republicans, seven Democrats and two independents—have served on the five-member Board in the last sixteen years. In the same period, six individuals have served as the Board's Chairman.

⁴ As the Board itself has recognized, the appellate courts have become increasingly critical of the agency's failure to develop cogent decisional principles that pay heed to the congressional admonition against the "proliferation" of bargaining units in the health care industry. Notice of Proposed Rulemaking, 52 Fed. Reg. 25,142-43 (1987) (citing cases).

lows the Board to "hide" behind its own rules, routinely invoking them as the justification for arbitrary certifications of manifestly *inappropriate* bargaining units.

5. The legislative history of the 1974 Amendments makes plain that Congress struck a careful and delicate balance between its desire to protect the right of workers to organize and bargain collectively with their employers and a recognized need to protect against employment relations instability at the nation's health care institutions and corresponding escalations in the cost of treatment. The Board's new unit determination rules substantially disrupt that balance and, consequently, undermine the important policies embodied in the governing statute.

Collective bargaining can be an exceedingly expensive proposition. New contracts, for example, are typically the product of months of negotiations that consume the time, energy and financial resources of employers and labor unions alike. More importantly, "collective bargaining gone awry" is even more expensive. Particularly in the health care industry, the potential for strikes, work slowdowns and other labor disruptions clearly threatens direct interference with day-to-day patient care and a serious escalation of costs.

As the Board has repeatedly acknowledged, the Ninety-Third Congress was especially sensitive to the health care industry's unique vulnerability to labor disruptions and the ever-increasing costs of personnel administration. It was clearly this concern, moreover, that motivated Congress both to preserve the existing "case-by-case" approach to the administrative determination of unit "appropriateness" and to admonish the Board to avoid the "proliferation" of bargaining units in health care institutions. The draftsmen of the 1974 Amendments preserved section 9(b)'s requirement that the Board determine bargaining unit appropriateness "in each case" precisely because they feared that, given the diversity inherently characterizing the health care industry, any

other approach might result in arbitrary and costly certifications of manifestly *inappropriate* units.⁵ Likewise, Congress expressly cautioned the Board to avoid the "proliferation" of bargaining units in the health care industry largely "because it feared frequent strikes that would close hospitals and increase[] the cost of medical care through wage 'leapfrogging' and 'whipsawing' if hospital employees were represented by many different unions." *Beth Israel Hospital & Geriatric Center v. NLRB*, 688 F.2d 697, 700 (10th Cir.) (*en banc*), cert. dismissed, 459 U.S. 1025 (1982). The Board's new rules flout those public policy concerns and, in turn, will ultimately accomplish precisely the opposite of what the draftsmen of the 1974 Amendments intended.

6. In SHRM's view, it also bears emphasis that the administrative proceedings that led to the adoption of the new rules were seriously flawed. As even the Court of Appeals recognized, the Board "overlook[ed] a great deal of relevant diversity" in the industry—diversity that renders impossible generalizations with respect to the "appropriateness" of particular bargaining units. *American Hospital Association v. NLRB*, 899 F.2d 651, 659 (7th Cir. 1990) (hereinafter cited as "*AHA II*"). Perhaps more importantly, however, the Board *did* give "controlling weight" to evidence of prior organizing patterns in the industry—an approach that the NLRA itself expressly forecloses.

Upon careful reading, the various notices of proposed rulemaking in this case strongly suggest that the Board settled upon the eight "presumptively appropriate" bar-

⁵ See, e.g., Bumpass, *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L. Rev. 867, 921 (1979) (surveying legislative history of 1974 Amendments and concluding that, in Congress' view, "the Board [could] adequately consider traditional criteria [of bargaining unit appropriateness] and congressional intent only through case by case analyses").

gaining units enumerated in the final rule largely on the basis of the "history" of collective bargaining in health care institutions. See, e.g., NPR II, 53 Fed. Reg. at 23,910-11. Section 9(c)(5) of the Act expressly provides, however, that "[i]n determining whether a unit is appropriate for the purposes specified in [section 9(b)], the extent to which the employees have organized shall *not* be controlling." 29 U.S.C. § 159(c)(5) (1982) (emphasis supplied). Thus, notwithstanding whether section 6 of the Act implicitly authorizes the Board to dispense with case-by-case determinations of bargaining unit "appropriateness," the present rules are plainly unenforceable as a matter of law.

For all of the foregoing reasons, this Court should reverse the judgment of the Court of Appeals and reinstate the District Court's permanent injunction against enforcement of the NLRB's health care bargaining unit determination rules.

ARGUMENT

I. THE BOARD'S NEW HEALTH CARE BARGAINING UNIT DETERMINATION RULES CONTRAVENE THE EXPRESS TERMS OF THE NLRA AND UNDERMINE THE INTENT OF THE DRAFTSMEN OF THE HEALTH CARE AMENDMENTS ACT OF 1974

1. Section 9(b) of the Act is not merely precatory. Instead, it provides that the NLRB "*shall* decide [the appropriate bargaining unit] *in each case*." 29 U.S.C. § 159(b) (1982). Thus, as this Court has repeatedly held, the Board must flexibly examine the facts of each individual case to determine whether the certification of a proposed bargaining unit would further the goals of the Act. See, e.g., *NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985). Indeed, the NLRB has no choice but to adjudicate representation cases on their individual merits, inasmuch as "[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be

by decision." *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947) (emphasis supplied).

Wide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit. Congress was informed of the need for flexibility in shaping the unit to the particular case and accordingly gave the Board wide discretion in the matter The flexibility which Congress thus permitted has characterized the Board's administration of the section and has led it to resort to a wide variety of factors in case-to-case determination of the appropriate unit.

Hearst Publications, supra, 322 U.S. at 134.

The Act does not, however, merely "facilitate" administrative flexibility in the determination of appropriate bargaining units. Instead, it affirmatively *requires* the Board to decide what unit is "appropriate" on an individualized, case-by-case basis. *E.g.*, *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 360 (3d Cir. 1976) ("Congress has . . . mandated Board determination 'in each case' of 'the unit appropriate' for collective bargaining. Thus[,] the statute *requires* the Board to exercise its discretion as to an appropriate unit *in each and every case.*") (emphasis supplied).⁶ In turn, and as the Board itself has recognized, "irrebutable presumption[s] of the appropriateness of . . . units in all cases, *without regard to particular circumstances*, should be disavowed. Such

⁶ See also *Big Y Foods, Inc. v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981) ("The only pertinent limitation [on the Board's role as the arbiter of representation disputes] is the § 9(b) statutory direction to the NLRB to make a decision 'in each case' [T]hat statutory direction invalidates a conclusive presumption [with respect to bargaining unit appropriateness] *because it precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees.*") (citations omitted) (emphasis supplied); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979) (Section 9(b) "requires the Board to exercise its discretion as to an appropriate unit *in each and every case.*") (emphasis supplied) (quoting *Memorial Hospital v. NLRB*, 545 F.2d 351 (3d Cir. 1976)).

a *per se* approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide 'in each case' whether the requested unit is appropriate." *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980).

2. The legislative history of the 1974 Amendments to the NLRA makes plain that Congress considered it imperative for the Board to adopt a "flexible" approach and determine bargaining unit "appropriateness" in the health care industry on a considered, case-by-case basis. Indeed, prior to its recent adoption of *per se* unit determination rules, the Board itself had repeatedly acknowledged its special obligation to resolve representation disputes involving health care institutions on the basis of careful, individualized analyses of *case-specific* circumstances. See, *e.g.*, *St. Francis Hospital*, 271 NLRB 948, 951 n.17 (1984) (hereinafter cited as "*St. Francis II*") (adopting "disparity of interests" test that "establishes neither a minimum nor maximum number of appropriate bargaining units [in the health care industry], but rather permits the determination to be made *on the facts of the particular facility involved*" and holding that "this approach comports with Congress' intent that the Board . . . deal[] with unit determinations *on a case-by-case basis*") (emphasis supplied).⁷ The dispositive point, however, is that the Board is *not* at liberty to reinterpret the governing statute and dispense with case-by-case consideration of representation questions. The draftsmen of the 1974 Amendments repeatedly emphasized the par-

⁷ As the District Court held, the inconsistency between this prior administrative interpretation of section 9(b) and the Board's more recent insistence that the Act empowers it to dispense with "in each case" adjudications of bargaining unit appropriateness affirmatively undermines the agency's current legal position. "When, as here, an administrative agency vacillates in its interpretation of an authorizing statute, its interpretation is entitled to little deference." *American Hospital Association v. NLRB*, 718 F. Supp. 704, 711 n.12 (N.D. Ill. 1989) (citing *NLRB v. United Food & Commercial Workers Union*, 484 U.S. 112, 124 n.20 (1987), and *County of Washington v. Gunther*, 452 U.S. 161, 177-78 (1981)).

ticular importance of administrative "flexibility" in cases involving health care institutions and made a conscious, independent decision to *preserve* section 9(b)'s requirement that the Board determine the "appropriateness" of proposed bargaining units "in each case."⁸ In turn, and as several circuit courts have held, the Board is necessarily *precluded* from relying upon irrebuttable decisional or regulatory "presumptions" with respect to the propriety of proposed bargaining units in the health care industry.

A brief survey of various events preceding Congress' enactment of the 1974 Amendments illustrates the point well. Congress first considered the possibility of extending the coverage of the NLRA to the employees of nonprofit hospitals in 1972, when Congressmen John Ashbrook and Robert Thompson introduced a bill, H.R. 11357, that would have repealed outright the preexisting exclusion of such institutions from the definition of "employers" set forth in section 2(2) of the Act. See *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974*, 93d Cong., 2d Sess. 105-06, 270 & 290 (1974) (hereinafter cited as "*Leg. Hist.*"). The House Education and Labor Committee reported the bill favorably to the full House, which approved H.R. 11357 on August 7, 1972. *Id.* at 105. The bill ultimately died in the Senate, however, after several legislators expressed concern that "provisions should be included which would accommodate the special characteristics of the industry." Bumpass, *supra* note 5, at 885 n.105.

The following year, shortly after the first session of the Ninety-Third Congress convened, Congressmen Ashbrook and Thompson introduced a second bill, H.R. 1236,

⁸ See, e.g., *St. Francis Hospital of Lynwood*, 601 F.2d at 415-16 (concluding that, with respect to proposed bargaining units in health care institutions, Congress "demand[ed] individual examination by the Board, or its delegate, of the circumstances of each particular case").

calling for outright repeal of the nonprofit hospitals exemption. *Leg. Hist.* at 106, 270 & 465. Meanwhile, Senators Alan Cranston and Jacob Javits introduced an identical proposal, S. 794, in the Senate. *Id.* at 106. In response, Senator Robert Taft introduced an alternative bill, S. 2292, that would have repealed the exemption, but also would have provided for a maximum of four "presumptively appropriate" bargaining units in health care institutions. *Id.* at 106-11 & 457-58.

Senator Taft's staff coordinated the extensive negotiations that ensued among sponsors of the alternative proposals, health care industry lobbyists and representatives of the labor movement. See Bumpass, *supra* note 5, at 883. The compromise legislation that emerged, S. 3203, did *not* set forth any "presumptions" with respect to the appropriateness of particular collective bargaining units. The proponents of outright repeal of the nonprofit hospitals exemption ultimately agreed, however, that Congress should specifically admonish the Board to "prevent[] proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974), reprinted in 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974).

There is but one fair inference to be drawn from this sequence of events. S. 3203, the bill that the Ninety-Third Congress ultimately adopted, was a substantive compromise between those who favored express limitations on the number of "presumptively appropriate" bargaining units in the health care industry and others who favored extension of the Act's protections to the employees of nonprofit hospitals without any accompanying special protections for health care providers and their patients. Stated alternatively, Congress decided to extend the Act's coverage to nonprofit hospitals, but only with specific safeguards, including an explicit directive that the Board avoid unit proliferation. Congress made a conscious determination, moreover, that it could best protect against escalating costs in and possible disruptions of

the nation's health care delivery system by *preserving* section 9(b)'s "in each case" procedural requirement.⁹

The Board's promulgation of *per se* unit determination rules is clearly inconsistent, therefore, with the Ninety-Third Congress' vision of precisely how the NLRB would resolve representation disputes in the health care industry. Indeed, as Member Johansen pointedly indicated in his dissent from the Second Notice of Proposed Rulemaking, the Board has simply ignored the requirements of section 9(b) and the import of the circumstances surrounding the enactment of the 1974 Amendments.

I do not read [section 9(b)] as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking *per se*. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to note that Congress did *not* amend Section 9 when it enacted the Healthcare amendments in 1974. Had

⁹ In the most exhaustive survey to date of the legislative history of the 1974 Amendments, T. Merritt Bumpass characterizes S. 3203 as a "compromise approach" to the "application of traditional bargaining unit criteria in the health care industry," Bumpass, *supra* note 5, at 886, and concludes that Congress imposed significant limitations on the Board's authority to establish irrebutable "presumptions" with respect to bargaining unit "appropriateness."

The existence of . . . general rules affords employees, labor organizations, and health care institutions the predictability needed in the creation of bargaining units and promotes the efficiency of administrative and judicial processes. *However, when parties dispute the propriety of proposed bargaining units, the Board can adequately consider traditional criteria and congressional intent only through case by case analyses. Only when the Board examines the personnel, organizational structures, and operations of the institution in which a unit is sought can it give due consideration to the congressional mandate against the proliferation of bargaining units.*

Id. at 921 (emphasis supplied).

Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action.

NPR II, 53 Fed. Reg. at 33,935 (Member Johansen, dissenting) (emphasis in original).

As it must, the Board concedes that its new unit determination rules effectively foreclose future case-specific determinations of bargaining unit appropriateness. Henceforth, absent "extraordinary circumstances," the Board will treat the eight narrow collective bargaining units enumerated in the rules as "the *only* appropriate units" in the health care industry. 29 C.F.R. § 103.30 (1990) (emphasis supplied).¹⁰ The new rules are so inherently restrictive, therefore, that they cannot be considered mere "guideposts" for future, case-by-case determinations of bargaining unit "appropriateness." To the contrary, because the Board purports to have "carefully considered" Congress' nonproliferation mandate in the course of its rulemaking proceedings, *see, e.g.*, Final Rule, 54 Fed. Reg. at 16,337, health care providers will be entirely precluded in future cases from citing or relying upon the legislative history of the 1974 Amendments and its special implications in case-specific circumstances. Indeed, the Board clearly expects its unit determination rules to *themselves* "decide" future cases. It is precisely this feature of the Board's new approach, however, that renders the rules unenforceable. Section 9(b) *mandates* that the Board determine an appropriate unit "in each case." As the legislative history of the 1974 Amendments makes plain, moreover, Congress considered this requirement nowhere more important than in cases involving the health care industry. Notwithstanding whether the Board's procedural approach might be "administratively convenient," therefore,

¹⁰ See note 2, *supra*, and accompanying text.

its unit determination rules are unenforceable as a matter of law.¹¹

3. As indicated, Congress also specifically directed the Board to "prevent[] proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974), reprinted in 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). The agency itself has repeatedly acknowledged that this nonproliferation admonition constitutes a binding congressional "directive," *St. Francis II*, 271 NLRB at 951, and that the Board's "consideration of the issues related to the composition of bargaining units in the health care industry must necessarily take place against the background of avoidance of undue proliferation." *The Jewish Hospital Association of Cincinnati*, 223 NLRB 614, 616 (1976). See also NPR II, 53 Fed. Reg. at 33,904-05 & 33,933 (congressional admonition against unit proliferation is mandatory, rather than permissive). Even more significantly, all but one of the circuit courts to consider the question have so held.¹²

¹¹ To so hold, this Court need only look to familiar canons of administrative law. "[I]f [agency] action is based upon a determination of law as to which the reviewing authority of the courts . . . come[s] into play, an order may not stand if the agency has misconceived the law." *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943) (emphasis supplied). Here, the Board has clearly "misconceived" the import of section 9(b)'s "in each case" requirement. Accordingly, its unit determination rules cannot be sustained. Cf. *Prill v. NLRB*, 755 F.2d 941, 947 (D.C. Cir.) (reviewing court must refuse to sustain unit determination "where it is based not on the agency's own judgment but on an erroneous view of the law"), cert. denied, 474 U.S. 948 (1985).

¹² See, e.g., *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1538-39 (11th Cir. 1984); *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632-33 (2d Cir. 1983); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191, 193-94 (4th Cir. 1982); *HMO International*, 678 F.2d at 808; *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980); *Allegheny General Hospital*, 608 F.2d at 968-69; *Bay Medical*

In the present case, the Court of Appeals lent credence to the majority interpretation of the "admonition" appearing in the 1974 committee reports and treated the nonproliferation mandate as "equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action." *AHA II*, 899 F.2d at 658.¹³ The Respondent does not dispute this finding and, for that matter, appears to concede that the only relevant question for this Court is whether "the Board's consideration of the issue of proliferation has been sufficient." Brief for the National Labor Relations Board on Petition for a Writ of Certiorari at 14. Having framed the dispositive issue in this way, however, the Board cannot hope to prevail. The section 103.30 unit determination rules inherently encourage unit proliferation, both by dispensing with case-by-case determinations of bargaining unit "appropriateness" and by establishing a greater number

Center v. NLRB, 588 F.2d 1174, 1177-78 (6th Cir. 1978), cert. denied, 444 U.S. 827 (1979). But see *International Brotherhood of Elec. Workers, Local 474 v. NLRB*, 814 F.2d 697, 712-14 (D.C. Cir. 1987).

¹³ In that regard, the lower court's discussion of the significance of the committee reports cogently illustrates precisely why the D.C. Circuit erred in concluding that the Board is effectively free to ignore the congressional admonition against the proliferation of bargaining units in the health care industry. See *International Brotherhood of Elec. Workers*, 814 F.2d at 712.

The admonition . . . accompanied the enactment of substantial amendments. The particular statutory provision to which the admonition was addressed was not amended, but the effect of the amendments was to apply that provision for the first time to the nonproprietary hospital industry. Section 9(b) directs the Board to determine the "appropriate" unit, and what is appropriate may differ from one industry to another—may therefore "mean" something different in one industry from what it means in another. So in changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words. The admonition can therefore be regarded as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history

AHA II, 899 F.2d at 658.

of discrete units than the Board has been willing to certify in almost any other identifiable "industry." In turn, this Court must hold that the rules are unenforceable as a matter of law.

The "nonproliferation mandate" appearing in the 1974 committee reports affirmatively precludes the Board from establishing, either by rule or adjudication, definitive "presumptions" with respect to bargaining unit "appropriateness." In *St. Francis Hospital of Lynwood*, for example, the Ninth Circuit explained as follows its refusal to approve a Board "presumption" in favor of the appropriateness of bargaining units comprised solely of registered nurses.

The key question raised herein is whether the *per se* policy established in the Board's *Mercy* decision¹⁴ (that a bargaining unit of registered nurses is irrebuttably appropriate when sought in a non-profit hospital) is consistent with the Congressional directive that the Board give "due consideration" to preventing undue proliferation of bargaining units in the health care industry and Congress's expressed approval of the trend towards broader units in this area. We conclude that it clearly is not.

From the legislative history of the 1974 Amendments . . . , it is apparent that Congress sought to encourage the Board to find broader bargaining units in the health care industry rather than narrower ones. The [*Mercy* precedent contravenes that congressional admonition by establishing an irrebuttable presumption in favor of certain units

Moreover, the *per se* policy as applied by the Board herein prevents the [employer] from presenting any evidence to demonstrate that the circumstances in its case . . . might justify an all-professional unit. *By setting up a policy which is automatically applied and irrebuttable without any examination of the particular situation involved, the Board fails to give "due consideration" to the congressional directive in that case.*

¹⁴ *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975).

St. Francis Hospital of Lynwood, 601 F.2d at 414 (footnote omitted) (emphasis supplied). The congressional admonition necessarily requires, in other words, that the Board conduct "independent evaluation[s]" of bargaining unit appropriateness "in [each] particular hospital." *Mercy Hospital Association*, 606 F.2d at 27-28.

In that regard, the Board's new unit determination rules obviously undermine congressional intent. Indeed, the only difference between the present case and *St. Francis Hospital of Lynwood* is that there are now *eight* irrebuttable "presumptions" with respect to bargaining unit appropriateness at issue. The Board nevertheless maintains that its thirteen years of "experience" in the field justifies the establishment of such presumptions, given that "what some have termed 'sensitive, case-by-case adjudication' " does not "appear" to have served "any useful purpose." NPR II, 53 Fed. Reg. at 33,901. It simply is not within the Board's purview, however, to make that determination.

Perhaps more important than the legal and procedural impropriety of the Board's new approach, however, is its indefensible practical effect. The new rules envision as many as eight separate bargaining units at an acute-care hospital, regardless of its size, its organizational structure or the extent to which its employees "cross-train" and interact as a necessary function of their day-to-day responsibilities. In contrast, the Board has typically been willing to certify as "appropriate" only *four* broad units—all professional employees, all production and maintenance employees, all technical employees and all clerical employees—in other industries. Bumpass, *supra* note 5, at 903. The generally recognized exception is the construction industry, wherein the Board has consistently certified separate bargaining units for "virtually *every* professional interest or job classification." *Mercy Hospital Association*, 606 F.2d at 27 (emphasis in original). As the draftsmen of the 1974 Amendments made plain, however, Congress' admonition against "unwarranted unit frag-

mentation" was motivated by a concern that "[h]ealth-care institutions . . . not be permitted to go the route of other industries, particularly the construction trades, in this regard." 120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied).¹⁵ Indeed, Congress admonished the Board to avoid bargaining unit "proliferation" precisely because it wished "to stress the necessity [that] the Board . . . reduce and limit the number of bargaining units in a health care institution" and, consequently, find appropriate only the *broadest* possible units. 120 Cong. Rec. 12,944 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied). Thus, by providing for a far *greater* number of bargaining units in health care institutions than in virtually any other industry, the Board's new rules directly undermine congressional intent. Accordingly, this Court should hold that the section 103.30 unit determination rules are unenforceable as a matter of law.

II. THE PROMULGATION AND ENFORCEMENT OF *PER SE* UNIT DETERMINATION RULES IN THE HEALTH CARE INDUSTRY UNDERMINES THE IMPORTANT PUBLIC POLICIES EMBODIED IN THE 1974 AMENDMENTS TO THE NLRA

The courts below quite properly focused on the question of whether the Board's new unit determination rules are consistent with the precise terms of the NLRA itself and the legislative history of the 1974 Amendments. And in that regard, the Society submits that this is a clear

¹⁵ The Board reads this expression of congressional intent narrowly, arguing that legislators were concerned *only* with "the possibility of scores of units" that had plagued the construction trades. NPR II, 53 Fed. Reg. at 33,933. See also *Allegheny General Hospital*, 239 NLRB 872, 875 (1978), *enforcement denied*, 608 F.2d 965 (3d Cir. 1979). Congress clearly intended, however, "that health care institutions be spared *not only* the 'egregious' unit proliferation of the construction industry, but also the less extreme unit fragmentation caused by applying traditional unit criteria." Bumpass, *supra* note 5, at 893 n.166 (emphasis supplied) (discussing *Mercy Hospital Association*, 606 F.2d at 27).

case. From the perspective of this *amicus*, however, the fatal flaw in the Board's new approach is that it flouts the important *policies* that the Ninety-Third Congress sought to protect. The 1974 Amendments to the NLRA strike an exceedingly delicate balance between competing legislative goals—namely, protecting the organizational rights of health care workers, while at the same time guarding against employment relations instability and corresponding cost escalations in the health care industry. The new rules upset that balance and, accordingly, undermine the entire framework of the governing statute.

The Ninety-Third Congress clearly recognized "that the hospital industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that 'Hospital care is not storable.'" *St. Francis Hospital of Lynwood*, 601 F.2d at 411 (quoting S. Rep. No. 766, 93d Cong., 2d Sess. 39 (1974) (individual views of Sen. Dominick), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3953). Indeed, the legislative history of the 1974 Amendments is pervaded with expressions of concern "that egregious unit proliferation . . . could impede effective health care delivery." *Presbyterian/St. Luke's*, 653 F.2d at 457. Accordingly, for reasons aptly summarized by Senator Taft, Congress sought both to preserve administrative "flexibility" in the determination of bargaining unit appropriateness and to *prevent* "unwarranted unit fragmentation" in health care institutions.

[T]he Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented.

The administrative problems from a practical operation viewpoint and labor-relation[s] viewpoint must

be considered by the Board on this issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.

In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft).

Congress' concerns in this regard were eminently realistic. Indeed, it stretches credulity for the Board to have concluded that the health care industry is *not* particularly vulnerable to labor relations instability flowing from bargaining unit "proliferation," or that "unit fragmentation" does not threaten serious escalations of the cost of medical care. See, e.g., Final Rule, 54 Fed. Reg. at 16,339; NPR II, 53 Fed. Reg. at 33,903. Putting aside that the Board clearly was not at liberty to substitute its judgment for Congress' prior conclusion that a "multiplicity" of bargaining units would in fact disrupt the nation's health care delivery system, the agency's conclusions simply defy common sense.

For a variety of reasons, the pattern of bargaining units which is established . . . is of considerable significance to health care institutions, their employees . . . and to the general public. *The numbers and types of units established can reasonably be expected to have an impact on the incidence of labor disputes in health care institutions, and thus upon the interruption of the delivery of services by such institutions, the costs of health care services [and] the administrative burden of managing health care institutions . . .*

Bumpass, *supra* note 5, at 868 n.8 (emphasis supplied). As the Board itself recognizes, the direct costs of collec-

tive bargaining are exceedingly high. Hospitals typically expend between fifteen and fifty thousand dollars to negotiate a single collective bargaining agreement. Final Rule, 54 Fed. Reg. at 16,339. There are, moreover, significant costs associated with the day-to-day administration of such agreements, which typically require employers to establish complex (hence costly) mechanisms for the adjustment of employee grievances and progressive appeals of employee discipline. *Id.*

By far the most significant cost of collective bargaining, however, is the disruption that necessarily obtains when intractable labor-management disputes develop. If such disputes result in strikes, walkouts or work slowdowns, the consequences can be devastating. The direct cost to a health care employer of a single strike, including legal fees, replacement workers' wages and lost revenues, can in some circumstances exceed one million dollars. *Id.* Of course, the *indirect* costs are inestimable. They are typically borne, moreover, by the "consumers" of health care services—i.e., the patients whose interests are directly compromised by disruptions in hospital operations.

Congress likely recognized that, at some level, these "direct costs" represent the price that simply must be paid if health care workers are to enjoy the benefits of collective bargaining. The draftsmen of the 1974 Amendments sought to *minimize* such costs, however, to the fullest extent possible. Health care institutions' expenditures for contract negotiations, personnel systems administration and strike remediation are obviously a direct function of the number of bargaining units certified as "appropriate" at the facility, rather than the gross number of employees working under union contract. It is clearly safe to assume, for example, that a hospital will spend twice as much to complete a cycle of negotiations with eight collective bargaining units than it would in similar negotiations with only four units. To the extent that the workforce is unnecessarily frag-

mented, therefore, the costs of collective bargaining are likely to be unnecessarily high.

Costs are likely to escalate even further to the extent that employees must bargain with manifestly "inappropriate" bargaining units. Indeed, as the Board itself recognized only five years before it initiated rulemaking proceedings, the health care industry is particularly susceptible to the erroneous certification of "misconstituted" collective bargaining units. As a practical matter, "[t]he diverse nature of today's health care industry—including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc.—precludes any generalization as to the appropriateness of any particular bargaining unit." *St. Francis II*, 271 NLRB at 953 n.39.

By consciously electing to preserve section 9(b)'s requirement that the Board determine an appropriate bargaining unit "in each case," Congress clearly sought to minimize the unnecessary costs associated with the certification of manifestly "inappropriate" units. Similarly, by specifically admonishing the Board to prevent the "proliferation" of bargaining units in the health care industry, the draftsmen of the 1974 Amendments sought to avoid the costly "disruptions" that necessarily obtain as a result of unit fragmentation. Unfortunately, the Board's new rules directly undermine both legislative goals. Accordingly, they are unenforceable as a matter of law.¹⁶

¹⁶ The Board's cursory answer to these criticisms, which various commentators repeatedly voiced in connection with the rulemaking proceedings, is that "[t]here is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation." NPR II, 53 Fed. Reg. at 33,908. This perfunctory assertion badly misses the mark, however, given that bargaining unit "proliferation" has thus far been avoided in the health care industry. As indicated, the circuit courts have insisted upon strict adherence to the "nonproliferation mandate" and required the Board to decide representation cases on their individual merits, thereby "policing" any administrative ten-

III. THE BOARD'S HEAVY RELIANCE ON THE "HISTORY OF COLLECTIVE BARGAINING" IN THE HEALTH CARE INDUSTRY VIOLATES THE EXPRESS TERMS OF SECTION 9(c)(5) OF THE ACT AND RENDERS THE SECTION 103.30 UNIT DETERMINATION RULES VOID AND UNENFORCEABLE

Section 9(c)(5) of the Act, 29 U.S.C. § 159(c)(5) (1982), provides that "[i]n determining whether a unit is appropriate for the purposes specified in [section 9(b) of the Act,] the extent to which the employees have organized shall not be controlling." On its face, this provision clearly does not "prohibit the Board from considering the extent of organization as one factor, though not the controlling factor, in its unit determination." *NLRB v. Metropolitan Life Ins. Co.*, 380 U.S. 438, 442 (1965) (emphasis supplied). The Board cannot "evade" section 9(c)(5), however, "by purporting to base its decision on other factors when in truth it has been controlled by the extent of employee organization." *NLRB v. Western & Southern Life Ins. Co.*, 391 F.2d 119, 122 (3d Cir. 1968) (quoting *NLRB v. Sun Drug Co.*, 359 F.2d 408, 412 (3d Cir. 1966)). Courts must refuse to enforce the Board's unit determination orders, therefore, where the record "justifi[es an] inference . . . that the extent of organization may have controlled the decision." *Sun Drug*, 359 F.2d at 412.

The record of the administrative proceedings that led to promulgation of the section 103.30 unit determination rules not only justifies an "inference" that prior organizing patterns "may" have controlled the Board's decision, but affirmatively compels the conclusion that the Board placed unwarranted (and statutorily foreclosed) emphasis

dency to permit unwarranted unit fragmentation. The Board's new unit determination rules would supplant the existing protections offered by this appellate review system, however, with a series of improper, irrebutable "presumptions" that will necessarily lead to previously unexperienced unit proliferation.

on the "history" of collective bargaining in the health care industry. First, as the American Hospital Association noted in its original petition for a writ of certiorari in this case, "the rule itself provides nothing new. [It] establishes eight bargaining units that are quite similar to the units the Board initially designated as appropriate in the years following enactment of the [1974] Amendments" Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 23 (citing cases).¹⁷ Indeed, only eight years ago, the Board surveyed its prior decisions and abortively attempted to establish eight "presumptively" appropriate bargaining units in the health care industry that were definitionally quite similar to those now enumerated in its unit determination rules. *St. Francis Hospital*, 265 NLRB 1025 (1982) (only "potentially appropriate" bargaining units in the health care industry are those comprised of physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, skilled maintenance employees and guards). The necessary suggestion is, therefore, that the Board settled upon the eight definitionally distinct bargaining units enumerated in the new rules largely on the basis of the *preexisting* pattern of organization in acute-care hospitals.

A careful reading of the Board's successive rulemaking notices confirms that the agency selected the eight bargaining units defined in the rules in lieu of the various possible alternatives precisely because health care workers had previously organized along similar lines. The Board ultimately justified its refusal to define "broader"

¹⁷ See also Bumpass, *supra* note 5, at 902 (surveying cases decided in the five years immediately subsequent to Congress' enactment of the 1974 Amendments and concluding that the Board had settled upon the "appropriate[ness of nine] separate bargaining units" comprised of registered nurses, physicians, residual professional employees, technical employees, service and maintenance employees, maintenance department or powerhouse employees, business office clericals, chauffeur-drivers and guards).

units than those set forth in the final rules, for example, on the ground that "[h]istorically, health care workers [have] organize[d] and engage[d] in initial bargaining in occupationally homogeneous units." NPR II, 53 Fed. Reg. at 33,910. Similarly, NPR II's lengthy discussion of the alleged "appropriateness" of the eight separate bargaining units ultimately chosen by the Board includes repeated representations that the "history" of collective bargaining in the industry ultimately justifies "presumptions" in favor of the propriety of such units. See, e.g., *id.* at 33,913-14 (registered nurses), 33,919-20 (technical employees), 33,921 (skilled maintenance employees) & 33,925 (business office clericals). Indeed, all three rule-making notices are pervaded with "justifying" citations to *previous* Board decisions wherein the agency had certified as "appropriate" units similar to those enumerated in the final rules. See, e.g., Notice of Proposed Rulemaking, 52 Fed. Reg. 25,147 (justifying proposal to deem units of "technical" employees presumptively appropriate on grounds that "we have consistently approved separate units of health care technical employees and excluded technicals from units of other nonprofessional employees") (citing *Southern Maryland Hospital*, 274 NLRB 1470 (1985); *Newington Children's Hospital*, 217 NLRB 793 (1975); and *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975)).

Throughout these protracted discussions of the "history" of collective bargaining in the health care industry, moreover, the Board gives the distinct appearance of having acceded to the parochial and political desires of labor organizations. For example, the Board insists that separate units of registered nurses are "appropriate" because, according to the American Nurses Association, "RNs have for many years exhibited a strong desire for separate representation." NPR II, 53 Fed. Reg. at 33,913. Similarly, the Board justifies its determination that separate units of technical employees are *per se* "appropriate" partly on the basis of a bald statement that, "[a]t the [rulemaking] hearings, no union

organizer who was asked could recall any situation in which technical employees sought to [be] include[d in the same unit with] business office clericals or unskilled service workers, or vice versa." *Id.* at 33,920.

By far the most persuasive evidence that the Board considered the "history" of collective bargaining in the health care industry "controlling," however, is the suggestion in NPR II that rulemaking is *ultimately* justified by the "consistency" between the results reached in prior unit determination cases.

[I]n numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, *and even under adjudication the various Board members had reached virtually identical results from case to case.* Hence, it did not appear that what some have termed "sensitive, case-by-case adjudication" was serving any useful purpose.

NPR II, 53 Fed. Reg. at 33,901 (emphasis supplied).¹⁸ The only fair inference to be drawn from this sweeping

¹⁸ Indeed, the Board referred repeatedly to the presence of "recurring patterns" in its prior unit determination cases.

Our adjudicatory decisions as to appropriate units in the health care industry . . . have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings[,] the Board found RN units appropriate in 24 out of 25 published cases; technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc. . . . Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach.

NPR II, 53 Fed. Reg. at 33,903 (footnote omitted). Similar statements pervade the administrative record in this case. In turn, the Board simply cannot deny that it gave "controlling weight" to the "history" of collective bargaining in the health care industry.

statement is that the Board has embodied in its new rules broad "presumptions" that do little more than "codify" certain *prior* unit determinations—hence reflect the agency's intention to reach future such determinations *solely* on the basis of "prior organizing patterns." Thus, while the Board paid lip service to the relevance of various other indicia of bargaining unit appropriateness, it clearly treated as "controlling" the thirteen-year "history" of collective bargaining in the industry. *Cf. Western & Southern Life*, 391 F.2d at 122; *Sun Drug*, 359 F.2d at 1412.¹⁹

Section 9(c)(5) expressly forecloses such an approach. Accordingly, the Board's new unit determination rules are unenforceable as a matter of law.

¹⁹ Perhaps more egregiously, the Board's survey of the "history" of collective bargaining in health care institutions was plainly arbitrary. For example, as several commentators noted during the course of the rulemaking proceedings, the Board based its conclusions with respect to prior organizing patterns on an anecdotal analysis of relatively few representation cases. In any event, the Board should have recognized from the outset that its attempt to glean meaningful conclusions from an analysis of the history of collective bargaining in the health care industry was likely to be a wholly futile exercise. Less than thirty percent of the nation's health care employees work under union contract. Becker & Rakich, *Hospital Union Activity, 1974-85*, 9 Health Care Fin. Rev. 59, 65 (1988). Indeed, in many parts of the country, virtually no health care unions exist. *Id.* Thus, while analysis of health care industry "organizational patterns" in New York City and other major cities may be of interest, *see, e.g.*, NPR II, 53 Fed. Reg. at 33,911, it hardly justifies the promulgation of "presumptive" rules of general application.

CONCLUSION

For all of the foregoing reasons, as well as those set forth in the Brief for Petitioner, this Court should reverse the judgment of the Court of Appeals and reinstate the District Court's permanent injunction against the application and enforcement of the Board's health care unit determination rules.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,
Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD, *et al.,*
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Seventh Circuit

BRIEF OF UNION OF AMERICAN PHYSICIANS
AND DENTISTS, AS AMICUS CURIAE
IN SUPPORT OF RESPONDENTS

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BRIEF OF UNION OF AMERICAN PHYSICIANS
 AND DENTISTS, AS AMICUS CURIAE
 IN SUPPORT OF RESPONDENTS

This Brief Amicus Curiae is submitted in support of the position of the Respondents. Written consents from all parties have been obtained as required by Rule 37.2 of the Rules of this Court.¹

INTEREST OF THE AMICUS CURIAE

This Amicus Curiae brief is submitted by the Union of American Physicians and Dentists, (UAPD), in order to present the perspective of physicians who have been

¹ The written consents have been filed with the Clerk of the Court.

involved in the collective bargaining process. As an organization representing physicians and dentists in 11 states, the UAPD has litigated collective bargaining unit issues with respect to physicians before the NLRB, as well as other agencies. See, e.g., *FHP, Inc.* 274 NLRB 1141 (1985).

In its attempts to communicate and represent the interests of physicians, the UAPD testified at the NLRB rulemaking hearings and also filed an amicus brief while the instant case was pending below in the Seventh Circuit Court of Appeals.

SUMMARY OF ARGUMENT

The creation of a separate physicians unit through the rulemaking process is the most efficient method of reaching an inevitable result. Prior to rulemaking, the NLRB created separate physician bargaining units in such cases as *Montefiore Hospital*, 261 NLRB 569 (1982) and *Ohio Valley Hospital Association*, 230 NLRB 604 (1977).

None of the judicial challenges to the NLRB's interpretation of the Health Care Amendments has involved challenges to the creation of physician bargaining units. The debate between the Courts and the NLRB with respect to appropriate bargaining units in the health care industry has revolved around other employees, such as maintenance personnel. *International Brotherhood of Electrical Workers Local 474 v. National Labor Relations Board (St. Francis Hospital)*, 814 F.2d 697 (D.C. Cir. 1987).

In fact, prior NLRB precedent indicates that the creation of a separate physicians bargaining unit eliminates the possibility of proliferation of bargaining units caused by distinctions between physicians. *Montefiore Hospital, supra*; *New York University Medical Center, a Division of New York University*, 217 NLRB 522 (1975).

The NLRB's exercise of its rulemaking authority eliminates wasteful hearings which, based upon prior board

precedent and working conditions of physicians, would inevitably find that physicians are entitled to their own bargaining unit.

ARGUMENT

I. A SEPARATE BARGAINING UNIT FOR PHYSICIANS IS DICTATED BY PRIOR NLRB PRECEDENT AND THE WORKING CONDITIONS OF PHYSICIANS.

The separate physicians unit created by the NLRB's rulemaking process is completely consistent with prior NLRB precedent. The NLRB has proposed a separate physicians unit "because of physicians' separate education, training, and skills, and particularly because of their unique position as the ultimate supervisors of patient care. . . ." *Notice of Proposed Rulemaking I*, 52 Fed. Reg. 25142, 25147 (1987). This reasoning is virtually identical to the NLRB's decision in *Ohio Valley Hospital Association*, 230 NLRB 604 (1977), in which the NLRB excluded physicians from a bargaining unit of hospital professionals. In *Mon Valley United Health Services*, 238 NLRB 916, 924 (1978), the NLRB indicates, at Footnote 17, that physicians possess a separate and distinct community of interest from other professionals. In *Montefiore Hospital*, 261 NLRB 569 (1982), the NLRB established a unit of physicians and dentists providing health services for correctional institutions.

The creation of physicians bargaining units has not been a matter of controversy in the courts. Typically, challenges to the creation of a physicians unit are based on considerations other than fears of proliferation. For the most part, the issue of whether physicians are managerial or supervisory, rather than employees under the Act, has been the focus of attention. *FHP, Inc., supra*; *Montefiore Hospital, supra*.

The differences between the Courts and the NLRB regarding health care bargaining units have involved other

hospital employees, such as maintenance personnel or nurses. *International Brotherhood of Electrical Workers Local 474 v. NLRB*, *supra*; *NLRB v. Res-Care, Inc.*, 705 F.2d 1461 (7th Cir. 1983); *Mary Thompson Hospital, Inc. v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

II. A PHYSICIANS BARGAINING UNIT AVOIDS POSSIBLE PROLIFERATION BASED UPON SPECIALTY OR LOCATION.

NLRB precedent prior to the issuance of the health care rules illustrates that an overall physicians unit avoids proliferation caused by physicians specialties or location. For example, in *New York University Medical Center, a Division of New York University*, *supra*, the NLRB rejected a proposed unit of 60 psychiatrists who were members of the School of Medicine's Department of Psychiatry. The NLRB found that the psychiatrists had a broader community of interest with other physicians.

In *Montefiore Hospital*, *supra*, the NLRB created a unit of physicians and dentists from various locations of the employer, rather than granting bargaining unit status to each separate location.

These cases illustrate the accuracy of the observation made by the court below that the term "proliferation" has always referred to finer divisions of the health-care work force than attempted in the rule issued by the NLRB. (See, Pp. 13a-14a of Appendix to Petition for Writ of Certiorari.

CONCLUSION

No one in the health care industry seriously contends that physicians should not have a separate bargaining unit. The creation of a separate bargaining unit through rulemaking eliminates the necessity of time-consuming and wasteful hearings when representation petitions are filed. The NLRB's decision to issue a rule on this question is clearly the most efficient manner to

deal with the issue. Accordingly, the UAPD urges affirmation of the Seventh Circuit decision.

Respectfully submitted,

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